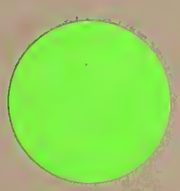
HOSPITAL INSURANCE BENEFITS

A PROGRAMMED LEARNING TEXT



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

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This booklet is intended primarily for those who need a basic understanding of Part A of Medicare. Information contained here is not all inclusive and does not alter or supersede regulations, operating procedures, or manual instructions.

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Additional copies of this booklet can be obtained by filling out the order form found at the back of this publication and mailing it to: Health Care Financing Administration, Office of Management and Budget, Office of Human Resources and Administrative Services, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235.

TO THE STUDENT

This is the second in a series of programmed learning texts covering the health insurance program. This text is limited to hospital insurance provisions. Before working through it, you should complete the first in the series, Medicare Enrollment, since this text assumes knowledge of certain basic material presented in Medicare Enrollment. It is preferred that you work through the current text before going on to the third in the series, Medical Insurance Benefits, but this is not mandatory.

This is not an examination, but a programmed learning text. You will get maximum benefit from it by following instructions carefully:

1. When a response is called for, write it in the space provided before checking your answer. This helps fix the correct answer in your memory.

2. If you choose an incorrect response, reread the frame or frames teaching that concept.

3. Proceed at your own best speed for reading and comprehension. Don't worry about how fast or slow someone else seems to be going.

Most of the pages in the text require the use of an "answer mask," which is provided on the back cover. Place the mask on the page so it reveals only the top frame, covering the answers at the right. After you have selected your response, slide the mask down to expose the correct answer and the next frame. Proceed in this manner until you are instructed otherwise.

Though the concepts which comprise the hospital insurance program under Medicare are interrelated, an attempt has been made in this text to focus on certain key concepts one at a time. The following page gives a breakdown of the contents, listing the pages covering each of these key concepts.

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--BENEFIT PERIOD--

--COINSURANCE--

--DEDUCTIBLE--

--JULIAN DATES--

PAGES 1 to 16

Medicare is a health insurance program for people 65 and older, for some people under 65 who are disabled, and for people of any age who have end-stage renal disease. The program has two parts. One part is called hospital insurance; the other part is called supplementary medical insurance. GO ON TO NEXT FRAME	
Medicare's hospital insurance (sometimes called Part A) can help pay for medically necessary inpatient hospital care, and, after a hospital stay, for inpatient care in a skilled nursing facility and for care at home by a home health agency. Supplementary medical insurance (Part B) covers physicians' care and other medical services and supplies. GO ON TO NEXT FRAME	
This programmed learning text will concentrate on the hospital insurance benefits part of the Medicare program. Supplementary medical insurance (Part B) will be the subject for a separate programmed learning text. GO ON TO NEXT FRAME	
The hospital insurance program provides coverage for inpatient hospital services for 90 days in each "benefit period." In addition, a beneficiary has a lifetime reserve of 60 days, each of which can be used only once during the beneficiary's lifetime. These covered services are subject to "deductible" and "coinsurance" provisions. Part A provides a maximum of _____ days of hospital services in a benefit period.	150 (90 + 60)
When all or part of the 60 lifetime reserve days are used up, they cannot be renewed, but the basic 90 days of covered services is reinstated whenever a new benefit period begins. If Jack used 20 of his lifetime reserve days in his first benefit period, in his next benefit period he would have a maximum of 90 regular days plus _____ days remaining in the lifetime reserve.	40

We will discuss the definition of "benefit period" later. Now let's talk about the terms "deductible" and "coinsurance." In each benefit period, the patient is responsible for a certain amount of inpatient hospital charges before Medicare can start to pay. The amount the patient is responsible for is called the inpatient hospital deductible and is equivalent to the average cost (nationally) of 1 day of hospital care. In each benefit period the amount of inpatient hospital charges the patient is responsible for is called the inpatient hospital _____.	deductible
For benefit periods beginning on or after January 1, 1980, the patient is responsible for the first $180 of inpatient hospital charges. This is the deductible. GO ON TO NEXT FRAME	
The term "coinsurance" as used in the Medicare program refers to the beneficiary's share of the cost of certain services. Ordinarily, Part A coinsurance is involved only in relatively long-term illnesses. Currently, the daily coinsurance rate per benefit period for hospitalization under Medicare from the 61st through the 90th day is $45. The coinsurance rate for the lifetime reserve days (91st through 150th days) is $90 per day. GO ON TO NEXT FRAME	
An easy way to remember the hospital coinsurance amounts is to remember that they are always a fraction of the current deductible amount -- 1/4 for 61st through 90th days and 1/2 for lifetime reserve days. 1/4 of $180 is _____ (coinsurance for 61st - 90th days) 1/2 of $180 is _____ (coinsurance for lifetime reserve days)	$45 $90
Coinsurance has the effect of extending Medicare benefits over a longer period at less cost to the program by having the beneficiary share the cost. The beneficiary knows that expenses incurred for covered services will be limited to an amount that can be financed, or covered by supplementary private insurance. For instance, the maximum coinsurance for the first 90 days of covered services would be $_____	$1,350 (61st - 90th day at $45 per day)

The maximum coinsurance for the additional lifetime reserve of 60 days would be $_____.	$5,400 (60 days at $90 per day)
With the deductible of $180 and the coinsurance amount of $45 for the 61st through the 90th day of inpatient care, we have two patient charges to remember. Josephine, who was hospitalized 75 days, would be responsible for a total of $_____.	$855 ($180 + $675)
When the hospital stay exceeds 90 days, we must remember a third item, the $90 coinsurance that applies to lifetime reserve days for benefit periods beginning on or after January 1, 1980. After the first 90 days, the coinsurance rate is $90 a day for the next _____ days.	60
Jack is hospitalized for 112 days in a benefit period. He would be responsible for $_____. (Do not omit any of the three factors.)	$3,510
The major benefit of the lifetime reserve provision is to give added protection to beneficiaries with long term illnesses. These are people who are continuously institutionalized, some of whom have, in effect, only one benefit period in their lifetime. But we still have not defined "benefit period" for you, have we? A "benefit period" begins the first day a beneficiary receives inpatient hospital services or extended care services and ends when the beneficiary has not been an inpatient of <u>any</u> hospital or skilled nursing facility for 60 consecutive days. GO ON TO NEXT PAGE	

The problem of determining the ending date of a benefit period gets pretty complicated because of our calendar system. If each month had an equal number of days, it would be easy. So you won't have to count on your fingers every time this question arises, we will teach you how to use the Julian calendar. The Julian calendar assigns a number, 1 - 365, to each day of the year. Of course, on leap year, the last day of the year, December 31, will be numbered _____.	366
The Julian calendar for regular and leap years is reproduced at the back of this book. Tear it off now for easy reference. Note that the calendar reads down, not across. It works just like a map mileage calculator. You select the column for the month at the top, and the row for the day at the side. The Julian date appears at the point where the month column and date row intersect. Example: (Regular years) (Julian date) January 15 015 July 15 196 October 15 ?	288
How did you do? Try a few more for practice--only this time use the leap year calendar. February 18 - March 13 - December 25 - July 4 -	02/18 - 049 03/13 - 073 12/25 - 360 07/04 - 186
Now the trick is to learn when to use the regular and when to use the leap year calendar. Leap years fall in 1972, 1976, and 1980, and every 4 years thereafter. Give the correct Julian dates in these examples. 1. July 4, 1975 2. December 25, 1973 3. April 1, 1976 4. September 5, 1974	185 359 092 248
To determine when a new benefit period can begin, first convert the date of discharge to a Julian date, then add 60, and reconvert the sum to a calendar date. Example: Date of discharge = August 9, 1976 Julian date = 222 (remember leap year!) add 60 282 = October 8, 1976 Now you try one. The Julian date for the first day in the new benefit period, if the date of discharge is March 15, 1975, is _____.	134

Now, the problem is converting Julian dates to calendar dates. We did that one frame back, without explaining, but you can easily see that you must find the Julian date on the chart, then read the month from the top of the column and the day from the end of the row in which the Julian date is located. Let's convert Julian date "134" from the example above:

	MAY	
14	134	

= May 14, 1975

GO ON TO NEXT FRAME

Try three more conversions of calendar dates to Julian dates. Watch out for those leap years!

a. October 31, 1976 = ?

b. April 15, 1974 = ?

c. June 11, 1973 = ?

a. 305 (leap year)

b. 105

c. 162

Great! Now you can figure the first day a new benefit period can begin, using calendar dates. Let's work a few problems:

Day of Discharge	First Day a New Benefit Period Can Begin
a. August 29, 1975	_____
b. May 3, 1976	_____
c. September 17, 1974	_____
d. January 1, 1977	_____

a. 301=10/28/75
b. 184=07/02/76
c. 320=11/16/74
d. 061=03/02/77

So what do you do if the period extends from one year into the next? It's easy! You do it the same way as usual; but if the sum exceeds 365 (366 in a leap year), you merely subtract 365 or 366, as appropriate, and add 1 to the year. For instance:

December 21, 1976 = 356
add 60
416
subtract 366
50 = February 19, 1976 + 1 = 1977.

Now try this one. Date of discharge is November 25, 1974. What is the first day the next benefit period can begin?

January 24, 1975

Again, try three problems to test your skill:

Day of Discharge	First Day a New Benefit Period Can Begin
a. December 3, 1976	_____
b. November 11, 1974	_____
c. November 5, 1977	_____

a. Feb. 1, 1977
b. Jan.10, 1975
c. Jan. 4, 1978

The Julian calendar also can be used for figuring the number of days of hospital care that have elapsed. Again, we start by finding the Julian date for the day of discharge. From this, subtract the Julian date for the day of admission. The remainder is the number of days of hospital care. Example:

John was admitted to Westside Hospital on July 5, 1975. His date of discharge was August 30, 1975.

August 30 = 242
July 5 = 186
56 days

GO ON TO NEXT FRAME

As you can see, this is a much simpler procedure since you do not have to reconvert the answer to a Julian date--it is already in the form you need. Try three problems in the next frame before we move on.

Date of Admission	Date of Discharge	Elapsed Days	
a. Feb. 13, 1976	May 1, 1976	_____	a. 78 days
b. Dec. 10, 1974 (Hint: Add 365 to Julian date for 01/05/75 before subtracting)	Jan. 5, 1975	_____	b. 26 days
c. July 31, 1976	Oct. 12, 1976	_____	c. 73 days

If you answered all the above, you have mastered the Julian date calendar. Congratulations!

Now get ready for a change of pace. The next several pages are arranged in "scrambled book" format, so you will not need to use the mask.

GO ON TO NEXT PAGE

ITEM 1 You have already learned that benefits will be provided for inpatient hospital services for 90 days in each benefit period with the patient paying the first $180 of inpatient hospital charges in a benefit period beginning in 1980. For each day after the 60th day (up to 90 days) that a patient receives benefits, the patient is responsible for a daily coinsurance of $45 a day. For each day after the 90th day that a patient receives lifetime reserve benefits, the patient is responsible for a daily coinsurance of $90 a day.

A benefit period begins the first day a beneficiary receives inpatient hospital services or extended care services and ends when the beneficiary has been out of any hospital or skilled nursing facility for 60 consecutive days.

Beneficiary Joan Shause entered Municipal Hospital on July 30, 1980, and was not released until October 10, 1980. Assuming that Joan is not required to enter a hospital or skilled nursing facility during the remainder of the year, what is her benefit period?

a. July 30 through December 8 (See Item 2)

b. July 30 through October 10 (See Item 3)

c. July 30 through September 27 (See Item 4)

ITEM 2 (1a) Right! Joan's benefit period lasts from July 30, the day she entered the hospital, through December 8, 60 days after her October 10 release date. We begin counting with October 10 (the day of her discharge). Joan's total hospital stay from July 30 to October 10 was a long one--72 days to be exact. Except for the $180 deductible and the $45 daily coinsurance for 12 days, the hospital insurance program will provide benefits to cover the cost of all ordinary inpatient hospital services for her 72-day stay.

Once a benefit period has started, it will be prolonged by each subsequent admission to any hospital or skilled nursing facility that occurs before the end of the benefit period. Thus, a benefit period could be extended indefinitely if a patient should be readmitted to any hospital or skilled nursing facility repeatedly at less than 60-day intervals. This is true whether or not the institution is participating in the Medicare program. Go on now to Item 5.

ITEM 3 (1b) October 10 is Joan's date of release from Municipal Hospital, but it is not the end of her benefit period. Joan's benefit period cannot end until she has been out of the hospital for 60 consecutive days starting with October 10 (date of discharge) as the first day out of the hospital. "Benefit period" is a technical term that refers to the period of time which begins with the first day a patient receives inpatient hospital or extended care services during a month in which the patient is entitled to benefits, and ends when the patient has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days. Now return to Item 1 and select another answer.

ITEM 4 (1c) July 30 through September 27 is the first period of 60 days that Joan spent in the hospital, the period for which she can receive benefits for inpatient hospital services after she has paid the $180 deductible. However, this is not her benefit period. A "benefit period" begins with the first day a patient receives inpatient hospital services or extended care services during a month in which the patient is entitled to benefits, but ends when the patient has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days (starting with the day of discharge). Go back to Item 1 and select another answer.

ITEM 5 During April 1980, beneficiary Alice Bolcher entered County Hospital for treatment of a stomach ailment. The total covered charges of her 10-day stay and treatment while in the hospital were $1,040. This was her only hospitalization during this particular benefit period. What part of the bill will be covered by the hospital insurance program?

a. The entire $1,040 (See Item 6)

b. $860 (See Item 7)

c. $630 (See Item 8)

ITEM 6 (5a) The entire $1,040. This is the total charge of Alice's ordinary inpatient hospital services. The amount we are interested in here, however, is the amount of the bill covered by hospital insurance. The patient is responsible for the first $180 of inpatient hospital charges in each benefit period. The hospital insurance program will then cover the balance. Now go back to Item 5 and choose another answer.

ITEM 7 (5b) Right! $860 will be covered by the hospital insurance program. You arrived at this amount by subtracting $180 from the $1,040 total cost of inpatient hospital services. The patient is responsible for the first $180 of such services and the hospital insurance then covers the balance. Now go on to Item 9.

ITEM 8 (5c) You are partially correct. You charged Alice for the first $180 of inpatient services. She is responsible for this amount. However, you have also included $45 a day for Alice's 10-day stay in the hospital. Remember, the first 60 days are not subject to a daily coinsurance only for the last 30 days of the 90-day period must the patient pay a daily coinsurance. Now go back to Item 5 and choose another answer.

ITEM 9 Beneficiary Sam Jones recently required 70 days of care in Mercy Hospital. He stayed in a semi-private room and received no special personal comfort services or conveniences. The charges for the hospital services during the 70-day stay were $7,280. Assuming that this was his only hospitalization during this particular benefit period, what part of the bill will be paid by the hospital insurance program?

a. $7,100 (See Item 10)

b. $6,650 (See Item 11)

c. $6,830 (See Item 12)

ITEM 10 (9a) $7,100 would be correct if Sam had spent only 60 days in the hospital. He would then pay the $180 deductible and hospital insurance would assume responsiblility for the rest. However, Sam spent 70 days in Mercy Hospital. Remember, for the last 30 of the 90 days for each benefit period, the patient must pay a daily coinsurance of $45. Sam is responsible for this coinsurance for the last 10 days of his 70-day stay. Go back to Item 9 and choose another answer.

ITEM 11 (9b) Very good! You remembered to apply several important rules to arrive at the correct figure covered by the hospital insurance program. $7,280 was the total charge for the ordinary services furnished by the Mercy Hospital. Of this amount, Sam pays the $180 deductible which is applied to each benefit period; and since he spent over 60 days in the hospital, he must pay $45 a day for each day over the 60th day (10 days - $450). He will be covered for 90 days in this benefit period before having to use any of his lifetime reserve days. After 90 days, Sam is responsible for $90 daily coinsurance up to the 150th day, assuming he has not previously used any of his lifetime reserve days. Beginning with the 151st day, Sam is responsible for <u>all</u> hospital charges. Go on to Item 13.

ITEM 12 (9c) You are partially correct. You remembered that the patient must pay a $45 daily coinsurance for the 61st through the 90th day of hospitalization during a benefit period. However, you forgot that he is also responsible for a $180 deductible for each benefit period. Please return to Item 9 and choose another answer.

ITEM 13 Here's another problem involving "benefit period."

Jim Keene, a nondisabled beneficiary, was born 09/05/12. On August 29, 1977, Jim entered the hospital. After he had been in the hospital for 2 weeks, Jim's doctor decided he was probably ready to go home and he was discharged on September 12.

However, Jim had only been home for 3 days before he began to have a slight relapse. On his doctor's orders, Jim entered a skilled nursing facility for continued rest and care on September 15. Slowly, his condition improved enough so that on October 27 he was able to return home.

Assuming that he remains home for the rest of the year, which of the following are inclusive dates for Jim's benefit period?

a. 08/29 through 12/25 (See Item 14)

b. 09/01 through 12/23 (See Item 15)

c. 09/01 through 12/25 (See Item 16)

d. 09/04 through 11/10 (See Item 17)

e. 09/04 through 12/25 (See Item 18)

ITEM 14 (13a) Your answer is "08/29 through 12/25." You have correctly determined that Jim's benefit period will end 12/25, 60 consecutive days after his discharge from the skilled nursing facility (counting October 27 as his first day out of the skilled nursing facility), but his benefit period does not begin with 08/29. Even though 08/29 is the first day Jim received inpatient hospital services, this did not occur during a month in which he was entitled to hospital insurance benefits. Except for disabled beneficiaries, or those entitled under the End-stage Renal Disease provision, an individual cannot be entitled to benefits under hospital insurance until the month he is 65 years old. Return to Item 13 and choose another answer.

ITEM 15 (13b) "09/01 through 12/23" is partly correct. Jim's benefit period begins with 09/01 because this is the first day he received inpatient hospital services during a month in which he was entitled to benefits. However, 12/23 is not the last day of the benefit period. In counting the 60-day period Jim was out of a hospital or skilled nursing facility, you have probably included the 2 full days between the hospital and skilled nursing facility stay, plus 58 days following the skilled nursing facility discharge. Although this is a 60-day period during which Jim was not in a hospital or skilled nursing facility, his benefit period does not end until he has been out for 60 consecutive days starting with the day of discharge. Return to Item 13 and choose another answer.

ITEM 16 (13c) Correct! Jim's benefit period extends from 09/01 through 12/25. These are inclusive dates, so a new benefit period could not begin before 12/26. 09/01 is the first day Jim received inpatient hospital services during a month in which he was entitled to benefits. Jim's benefit period did not begin during August because he could not become entitled to HI benefits until the month he attained age 65. 12/25 is the last day of his benefit period because it is the 60th consecutive day after his October 27 discharge from the skilled nursing facility, counting October 27 as Jim's first day out of the skilled nursing facility. Now go on to Item 19.

ITEM 17 (13d) You are probably a little confused here. Although 09/04 is the day Jim attained age 65, which is one of the requirements for entitlement to benefits under the hospital insurance program for nondisabled beneficiaries, it is not the first day of his benefit period. Jim's benefit period begins with the first day he receives inpatient services during a month in which he is entitled to hospital insurance benefits. Jim has been receiving these services since 08/29. Furthermore, the benefit period ends only after Jim has been out of a hospital or skilled nursing facility for 60 consecutive days. On September 15 he entered a skilled nursing facility. Hence, he has not been out of a hospital or skilled nursing facility for 60 consecutive days. Go back to Item 13 and choose another answer.

ITEM 18 (13e) Your answer is "09/04 through 12/25." You have correctly determined that Jim's benefit period will end with 12/25, 60 consecutive days after his October 27 discharge from the skilled nursing facility (counting October 27 as the first day out of the skilled nursing facility), but his benefit period does not begin with 09/04. Although 09/04 is the day Jim attained age 65, which is one of the requirements for entitlement to benefits under the hospital insurance program for nondisabled beneficiaries, it is not the first day of his benefit period. Jim's benefit period begins with the first day he receives inpatient services during a month in which he is entitled to hospital insurance benefits. Jim has been receiving these services since 08/29. Go back to Item 13 and choose another answer.

--COVERED INPATIENT HOSPITAL SERVICES--

PAGES 17 to 28

ITEM 19 The hospital insurance program provides benefits for different kinds of services. It gives protection against the cost of reasonable and necessary inpatient hospital services ordinarily furnished by hospitals to their inpatients. These services include room (semiprivate) and board, regular nursing care, drugs for the use of the patient in the hospital, and other medical services, supplies, appliances, and equipment which are a necessary part of the patient's treatment in the hospital. For example, wheelchairs and crutches for the use of the patient in the hospital would belong in this category.

The hospital insurance program does not cover services furnished for the patient's own convenience, such as a television set, private duty nursing, or a private room. (However, private rooms may be covered where they are medically necessary for the patient's treatment or where no other type of room is available and the beneficiary requires immediate hospitalization.) Also not covered by the hospital insurance program are physicians' services except those provided by medical and dental interns and residents participating in an approved teaching program. (Physicians' services are covered under Part B of Medicare, the supplementary medical insurance program.)

Which of the lists below contains only items that could be paid for under the hospital insurance program as inpatient hospital services?

a. Semi-private room and board; drugs; private duty nursing care. (See Item 20)

b. Drugs; semi-private room and board; surgeon's fee; regular nursing care. (See Item 21)

c. Semi-private room and board; drugs; regular nursing care. (See Item 22)

d. Semi-private room and board; regular nursing care; pathologist's fee. (See Item 23)

ITEM 20 (19a) Although semi-private room and board and drugs can be paid for under the hospital insurance program, private duty nursing care cannot. The hospital insurance program provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. Hospitals do provide for nursing care for their patients, but special private duty nursing care is considered to be an expense for which the patient is responsible over and above normal hospital expenses. Please return to Item 19 and choose another answer.

ITEM 21 (19b) You have correctly learned that drugs, semi-private room and board, and regular nursing care can all be provided under the hospital insurance program. Remember, however, that the cost of physicians' services would not be covered (except for the services of interns and residents-in-training under approved teaching programs). The hospital insurance program provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. A surgeon usually works in a hospital, but as a physician a surgeon's fees are not covered by the hospital insurance program. A surgeon's services are not among those furnished by the hospital. Please return to Item 19 and choose another answer.

ITEM 22 (19c) Excellent! Semi-private room and board, drugs, and regular nursing care can all be paid for under the hospital insurance program as inpatient hospital services. In some cases a private room can be furnished, but only where it is medically necessary for the treatment of the patient. If a beneficiary wanted a private room even though it was not medically necessary, the hospital insurance program would pay for the cost of a semi-private room and the beneficiary would make up the difference. Use the mask for the next page.

ITEM 23 (19d) Regular nursing care and semi-private room and board are two items ordinarily furnished to hospital inpatients; thus, they are covered by the hospital insurance program. A pathologist, however, is a physician, and, since hospital insurance does not cover the cost of physicians' services, a pathologist's fee could not be covered under the hospital insurance program. Remember that hospital insurance provides benefits to cover only those services ordinarily furnished by hospitals to their inpatients. In addition to the two items mentioned above, these include drugs and biologicals and any other ordinary medical supplies that are a necessary part of the patient's treatment in the hospital. Now return to Item 19 and choose another answer.

Before moving on to the next "scrambled page" problems, let's review some of the material already covered. The hospital insurance program provides a maximum of 150 days of hospital inpatient services: _____ (how many?) regular days, _____ (how many?) lifetime reserve days.	90 60
The basic 90 days of covered services is reinstated each time a new _____ _____ begins. The lifetime reserve days, once used, are never renewed.	benefit period
A benefit period begins the first day a beneficiary receives inpatient hospital or extended care services and ends when a beneficiary has not been an inpatient of any hospital or skilled nursing facility for ____ consecutive days.	60
Covered inpatient hospital services for the first 60 days are paid for by the hospital insurance program. The patient's share of the cost of the first 60 days is called the _____.	deductible
Fill in the amounts below for inpatient hospital services for benefit periods beginning in 1980: a. deductible _____ b. coinsurance (61st through 90th days) _____ c. coinsurance (lifetime reserve days) _____	a. $180 b. $45 c. $90

ITEM 24 Tom Fenton was hospitalized on April 2, 1980. By April 17, his doctor thought that he was well enough to return home and he was released; but on June 5, he was back in the hospital. This time Tom remained until September 18. Below is a chronological list of Tom's treatment and the cost of the services he received. He has never used any of his lifetime reserve days.

(April 2 begins a "benefit period.")

Date	Item	Cost
April 1	Doctor visits Tom's home	$10
April 2	Tom enters hospital	
↑	semi-private room and board, nursing	$125/day
(15 days*)	drugs prescribed by doctor (in hospital).	$50 (total)
↓		
April 17	Tom is discharged from hospital	
June 5	Tom reenters hospital	
↑	semi-private room and board, nursing	$125/day
(104 days*)	pathologist's fee (June 20) . .	$200 (total)
	laboratory tests (July 4) . . .	$40 (total)
↓	drugs prescribed by doctor (in hospital).	$100 (total)
September 17	Tom is discharged from hospital	

Calculate the amount of benefits that will be paid under the hospital insurance program for these services:

a. $11,125 (See Item 25)

b. $10,925 (See Item 26)

c. $14,985 (See Item 27)

d. $10,740 (See Item 28)

* In counting the number of days of hospitalization, include the day a patient is admitted to the hospital but do not count the day of discharge.

ITEM 25 (24a) You are partly correct. You correctly calculated the amount of benefits that will be paid but you included an extra service. The $200 pathologist's fee is not paid for by the hospital insurance program. The only physician's services covered are those furnished by medical and dental interns and residents participating in an approved training program. Please return to Item 24 and choose another answer.

ITEM 26 (24b) Very good! You have learned a number of important rules for computing benefits under the hospital insurance program. First, because Tom did not remain out of the hospital for 60 consecutive days, both periods of hospitalization came within the same benefit period. Therefore, the $180 deductible is applied only once. You also remembered that the patient must pay $45 a day for the last 30 days of the 90-day period for each benefit period, and $90 a day for days in the lifetime reserve period. Only the first 60 days are covered completely by hospital insurance (after the $180 deductible has been paid). The charges for covered services for Tom's illness are as follows:

119 days of semi-private room and board at $125 a day	$14,875
Drugs for use in hospital.	150
Laboratory tests	40
	$15,065

Since Tom was in the hospital for a total of 119 days, he must pay a a part of the charges (coinsurance) for covered services after the first 60 days. The hospital insurance program covers him for the first 60 days but he must pay $45 a day for the last 30 days of the 90-day period ($1,350). After the first 90 days, he uses days in his lifetime reserve, with coinsurance of $90 per day (29 days at $90 = $2,610). He must also pay the $180 deductible amount which is applied toward the first 60 days. So, he will pay a total of $4,140 ($1,350 + $2,610 + $180). The hospital insurance program will cover $10,925 of the total. Go on to Item 29.

ITEM 27 (24c) Just a minute! You have forgotten one important factor, the coinsurance. A patient is covered under the hospital insurance program for 90 days in each benefit period. A patient pays a $180 deductible and hospital insurance pays for all covered services for the first 60 days. However, for each of the next 30 days of the 90-day period that a patient spends in the hospital during the same benefit period, the patient must pay $45, and for the 91st through 150th day must pay $90 per day coinsurance. Now go back to Item 24 and select another answer.

ITEM 28 (24d) You have correctly calculated the amount of covered charges, but you must have forgotten the "benefit period" rule. A "benefit period" begins the first day a patient receives covered inpatient services from a qualified hospital or skilled nursing facility and ends when a patient has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days, beginning with the date of discharge. Tom was out of the hospital for only 50 days before he reentered, so the cost of his hospital services from April 2 to April 17 and from June 5 to September 17 are considered to be in the same benefit period. Now return to Item 24 and select another answer.

ITEM 29 Here is a similar set of data for the hospital costs incurred by beneficiary James Bogdan. All dates are for the year 1980. Assume that March 3 begins a benefit period and that no lifetime reserve days have been used.

Date	Item	Cost
March 3	Mr. Bogdan enters hospital	
↑	private room and board, nursing	$135/day
(17 days)	drugs prescribed by doctor	$60 (total)
↓	physician's charges	$80 (total)
March 20	Mr. Bogdan discharged	
June 6	Mr. Bogdan reenters the same hospital	
↑	semi-private room and board, nursing	$125/day
(58 days)	drugs and biologicals (through July 18).	$180 (total)
	drugs and biologicals (July 19 - August 3)	$140 (total)
↓	operating room fee (June 9)	$70 (total)
August 3	Mr. Bogdan discharged	

Select the total amount of benefits that will be paid under the hospital insurance program for these services:

a. $10,220 (See Item 30)

b. $10,280 (See Item 31)

c. $9,465 (See Item 32)

d. $10,400 (See Item 33)

ITEM 30 (29a) You are partially correct, but you have forgotten one important provision of the program. Only those services that are medically necessary for the treatment of the patient are covered. A private room, unless it is necessary for the treatment of the patient, is not covered. The semi-private rate will be paid and the patient is responsible for the difference. Now return to Item 29 and choose another answer.

ITEM 31 (29b) You have included the $80 physician's charges in the first benefit period. The hospital insurance program will not pay for physicians' services other than those services furnished by medical and dental interns and residents participating in an approved training program. Now return to Item 29 and choose another answer.

ITEM 32 (29c) Excellent! You correctly perceived that Mr. Bogdan was in the hospital for two separate "benefit periods." Therefore, the $180 deductible is applied twice (to the first 60 days of each benefit period). You also remembered that the physician's charge in the first benefit period would not be covered. You also correctly determined that the cost of Mr. Bogdan's private room in the first benefit period is not covered. Hospital insurance will pay the cost of semi-private accomodations ($125/day) and Mr. Bogdan is responsible for the difference.

March 3 - March 20

17 days' room and board at $125/day	$2,125
Drugs	60
Total	$2,185
Less $180 deductible	$2,005

June 6 - August 3

58 days' room and board at $125/day	$7,250
Drugs and biologicals ($180 plus $140)	320
Operating room fee	70
Total	$7,640
Less $180 deductible	$7,460
Total hospital insurance payment (both periods)	$9,465

Remember that the first 60 days of inpatient hospital services are covered completely by Medicare hospital insurance after the $180 deductible has been met. For the last 30 days of the 90-day limit, the patient pays coinsurance equal to 1/4 of the inpatient hospital deductible ($45/day at present). The coinsurance is $90 per day for the 60 days in the lifetime reserve. Since Mr. Bogdan did not exceed 60 days in either benefit period, he only pays the $180 deductible for each benefit period. Go on to Item 34.

ITEM 33 (29d) Time out! You have forgotten the "benefit period" rule. A "benefit period" begins the first day a patient receives inpatient services from a qualified hospital or skilled nursing facility and ends when a patient has not been an inpatient of any hospital or skilled nursing facility for 60 consecutive days. Mr. Bogdan was out of the hospital for over 70 days before he reentered in June; therefore, the $180 deductible is applied a second time. Now go back to Item 29 and choose another answer.

ITEM 34 Here is an additional fact you should know. An individual cannot receive hospital insurance benefits for services at just any institution that calls itself a hospital or skilled nursing facility. Generally, benefits will be paid for inpatient services only at a participating hospital or skilled nursing facility. These medical facilities must meet certain requirements pertaining to their purpose, organization, and operations. Now we'll turn to other benefits provided under the hospital insurance program. Go on to Item 35.

--EXTENDED CARE SERVICES--

PAGES 29 to 40

ITEM 35 Besides inpatient hospital services, the hospital insurance benefit also provides for the coverage of post-hospital extended care services. These benefits help pay for care in a participating skilled nursing facility (SNF) for those beneficiaries who require skilled nursing care or other skilled rehabilitation services on a daily basis for the continued care of a condition for which the patient had received hospital care, which as a practical matter could only be furnished by a SNF on an inpatient basis. Howevever, only "post-hospital" care is covered. The patient must first have had a medically necessary hospital stay of 3 or more consecutive days in a "qualified" hospital and then be transferred to a skilled nursing facility for continued treatment of the condition within 14 days of discharge from the hospital (except under certain conditions, when a longer period is permitted). (A "qualified" hospital must meet certain standards but need not necessarily be participating in the Medicare program.) The intent of this "extended care" provision is to permit patients, who no longer require all the services generally available only in a hospital, to move from a high-cost hospital bed to a lower cost SNF, thus making the hospital bed space available to patients who are more acutely ill.

Beneficiary Jennifer Smith recently spent 3 weeks receiving medically necessary treatment in City Hospital. City Hospital, although it was a qualified hospital, was not participating in the Medicare program; therefore, the cost of her stay was not reimbursable under hospital insurance. After her stay in the hospital, Jennifer was transferred directly to the Golden Age Nursing Home, a participating skilled nursing facility, for continued care of the illness for which she had been hospitalized. Jennifer required skilled nursing or skilled rehabilitation care on a daily basis which, as a practical matter, could only be furnished by a skilled nursing facility on an inpatient basis. Based on what you have learned so far, can Jennifer expect the cost of her nursing facility care to be paid for by the hospital insurance program?

a. Yes (See Item 36)

b. No. Jennifer's 3-week hospital stay does not qualify her for extended care benefits because she did not stay in a participating hospital. (See Item 37)

c. More information is needed. (See Item 38)

ITEM 36 (35a) Yes, she certainly could expect to get some help. Jennifer required skilled care on a daily basis for continued care of the illness for which she had been hospitalized which, as a practical matter, could only be furnished by a SNF on an inpatient basis, and was transferred to a participating skilled nursing facility immediately after her hospital discharge, which was, of course, within the 14-day requirement. Furthermore, she was hospitalized in a qualified hospital for 3 weeks, whereas the minimum requirement is only 3 days. The fact that the hospital stay was not paid for by Medicare would not affect her eligibility to receive benefits for post-hospital extended care.

Finally, a patient who has been discharged from a skilled nursing facility in which benefits were being received can again receive extended care benefits in the same benefit period (without reentering a hospital) if readmitted to any participating skilled nursing facility within 14 days of discharge for the receipt of covered care. Now go on to Item 39.

ITEM 37 (35b) You have decided that Jennifer's 3-week hospital stay does not qualify her for extended care benefits because she had not received covered inpatient services during her hospitalization. Based on what you should have learned so far, this answer is not correct. We have said that an individual can qualify for post-hospital extended care following a 3-day stay in any qualified hospital. Now return to Item 35 and choose another answer.

ITEM 38 (35c) You believe that more information is needed. Think about this again. So far you have learned requirements for post-hospital extended care. The patient must (1) require skiled nursing care or skilled rehabilitation care on a daily basis for continued care of the illness for which the beneficiary had been hospitalized which, as a practical matter, could only be furnished by a SNF on an inpatient basis, (2) have had a qualifying hospital stay of at least 3 consecutive days, and then (3) have been transferred to a participating skilled nursing facility for continued treatment of the same illness, generally within 14 days of discharge from the hospital. You have been given enough information to decide whether or not Jennifer meets these requirements. Please return to Item 35 and choose another answer.

ITEM 39 Medicare payments can be made for up to 100 days of care in a skilled nursing facility in a benefit period. For the first 20 days, payment is made in full for covered services. After 20 days, the patient is responsible for a daily coinsurance equal to 1/8 of the inpatient hospital deductible. For benefit periods beginning January 1980, this is $22.50 per day.

Jim Collins recently spent 30 days in a participating hospital and received covered inpatient services during his stay. He was then transferred to a skilled nursing facility. Mr. Collins remained in the skilled nursing facility for 30 days and received a covered level of care for all days. How much is Mr. Collins responsible for as his share of payment for the services received in the skilled nursing facility?

a. $225 (See Item 40)

b. $675 (See Item 41)

c. None (See Item 42)

ITEM 40 (39a) Right again! Mr. Collins qualified for coverage since he was an inpatient in a qualified hospital for at least 3 days and upon discharge was transferred immediately to the skilled nursing facility for the receipt of a covered level of care. You remembered that 20 days of post-hospital extended care services are paid for by Medicare and that, for any days in excess of the first 20, the patient pays a daily coinsurance equal to 1/8 of the inpatient hospital deductible (presently $22.50 per day). So Mr. Collins pays for 10 days at $22.50 per day, or $225. Go on to Item 43.

ITEM 41 (39b) The first 20 days of post-hospital benefits in a skilled nursing facility are paid for by hospital insurance. Only after 20 days must the patient pay a daily coinsurance equal to 1/8 of the inpatient hospital deductible. You have charged Mr. Collins $22.50 per day for his full 30-day stay. Now go back to Item 39 and choose another answer.

ITEM 42 (39c) None? Don't be so generous! The hospital insurance program will pay for services which Mr. Collins receives for the first 20 days. But after 20 days he must pay a daily coinsurance of $22.50 per day. So Mr. Collins must pay a coinsurance for the last 10 days of his 30-day stay. Please return to Item 39 and choose another answer.

There is an additional deductible we haven't yet talked about, namely, "the blood deductible." Due to this deductible, the Part B program does not pay for the first 3 pints of whole blood (or equivalent units of packed red blood cells) received by a beneficiary in a calendar year. One unit of packed red blood cells is equivalent to a pint of whole blood. However, a beneficiary who replaces, or has the blood replaced on their behalf, may not be charged for the replaced blood.

ITEM 43 Beneficiary Mrs. Louise Johnson was first hospitalized on March 14, 1980, and was released 40 days later. She received covered inpatient hospital services for the 40-day stay. Then, after spending a week at home, Mrs. Johnson was put in a skilled nursing facility by her doctor for continued treatment of the same condition. She spent 30 days in the skilled nursing facility and the total charge for covered services during the 30-day stay was $675. How much of this amount will be covered by the hospital insurance program and how much will Mrs. Johnson pay?

a. HI program - $675 Mrs. Johnson - $405 (See Item 44)

b. HI program - $675 Mrs. Johnson - None (See Item 45)

c. HI program - $675 Mrs. Johnson - $225 (See Item 46)

ITEM 44 (43a) You correctly figured that Mrs. Johnson will pay $22.50 per day for the last 10 days of her stay. Only the first 20 days are covered completely by hospital insurance. However, you have incorrectly included a $180 deductible that Mrs. Johnson must pay. Remember, the $180 deductible applies only to the inpatient hospital charges. For post-hospital skilled nursing services, the patient is responsible only for the $22.50 daily coinsurance applied to any days over 20 that the patient remains in the facility (up to 100 days). Now go back to Item 43 and choose another answer.

ITEM 45 (43b) Just a minute! You say that hospital insurance will pay the entire $675 for covered services. Remember, for any days over the first 20 that a patient spends in a skilled nursing facility, a patient must pay a daily coinsurance of $22.50 (1/8 of the inpatient hospital deductible). Louise was in the nursing facility for 30 days; thus, she must pay a coinsurance for the last 10 days. Now go back to Item 43 and choose another answer.

ITEM 46 (43c) Excellent! You understand the method of payment for covered services in a skilled nursing facility. Mrs. Johnson was hospitalized for more than the 3-day minimum requirement and was transferred to the skilled nursing facility within 14 days of her discharge from the hospital. So she qualified for benefits and the hospital insurance program paid for the first 20 days. For the last 10 days of her 30-day stay, Mrs. Johnson paid a daily coinsurance of $22.50 (1/8 of the inpatient hospital deductible). Now go on to Item 47.

ITEM 47 The post-hospital extended care provision covers the items and services generally furnished by skilled nursing facilities. These include room and board in semi-private (2-to 4-bed) accomodations or private accomodations (if medically necessary), nursing care, physical, occupational and speech therapy, and drugs which are ordinarily furnished by the facility to its patients. However, in no case can payment be made for any service, drug, or other item which could not be paid for under the hospital insurance program if furnished in a hospital.

Payment can also be made for the medical services of interns and residents-in-training and for other diagnostic and therapeutic services furnished inpatients of a skilled nursing facility by a hospital with which it has an agreement for the transfer of patients and the exchange of medical records.

Which of the following statements is true?

a. Post-hospital extended care services for which benefits can be paid are those generally furnished by skilled nursing facilities, such as room and board in semi-private accommodations, nursing care, and rehabilitative therapy, including some items for which payment could not be made under the hospital insurance program if furnished in a hospital. (See Item 48)

b. Under the extended care provision, benefits can be paid for services that are generally furnished by skilled nursing facilities and, in some cases, for services furnished by hospitals to inpatients of skilled nursing facilities. (See Item 49)

ITEM 48 (47a) Not so fast now. Although it is true that benefits are only paid for those post-hospital services generally furnished by skilled nursing facilities, payment can never be made for any service or item which could not be paid for under the hospital insurance program if furnished in a hospital. Please return to Item 47 and choose another answer.

ITEM 49 (47b) Very good! Benefits under this provision cover services generally furnished by skilled nursing facilities. These include room and board in semi-private accomodations, nursing care, and rehabilitative therapy. In addition, payment can be made for services furnished inpatients of a skilled nursing facility by a hospital with which it has an agreement for the transfer of patients and exchange of medical records (e.g., medical services provided by an intern or resident-in-training of a hospital, or other diagnostic or therapeutic services provided by a hospital). Payment could not be made, however, for any service, drug, or other item which could not be paid for under the hospital insurance program if furnished in a hospital. Now go on to Item 50.

ITEM 50 Many skilled nursing facilities provide long term supportive (or custodial) care in addition to the full-time skilled nursing care and other skilled rehabilitation services for patients just discharged from a hospital. However, coverage for care in a skilled nursing facility is available under Medicare only where the patient's condition requires, on a daily basis, skilled nursing care by, or under the supervision of, a licensed or skilled rehabilitation care nurse. If the services required are merely assistance to the patient's daily maintenance, such as bathing, dressing, going to the bathroom, taking medicine that could normally be self-administered, etc., they are not considered skilled nursing services, but are instead considered supportive or custodial care. The hospital insurance program was not intended to pay the costs of custodial care. The attending physician must certify that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which the patient received inpatient hospital services, which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. The doctor must make this certification when the patient is admitted, with recertification required within 14 days and again no later than every 30 days following the first recertification.

Irene Cooper was admitted to the Southside Skilled Nursing Facility immediately after discharge from a 5-day stay in the Southside Hospital. She had a broken arm that is now in a cast. She is scheduled to stay in the skilled nursing facility for 8 weeks. She cannot go home because she lives by herself and needs help in bathing, dressing, and going to the bathroom. In addition, she must take a teaspoonful of special vitamin syrup three times a day, and she cannot do this by herself because of her broken arm. As a matter of fact, someone has to feed her. The doctor expects she will be able to feed herself in 4 or 5 weeks if she does the exercises prescribed.

a. Irene will have her skilled nursing facility bill paid in full for the entire 8 weeks since the doctor has put her in the facility. (See Item 51).

b. None of the skilled nursing facility services will be paid by hospital insurance since the services required are primarily custodial in nature. (See Item 52)

c. Mrs. Cooper will have her skilled nursing facility care covered for the first 4 or 5 weeks until she can feed herself and take her own medicine. (See Item 53)

ITEM 51 (50a) That would be nice, but you made the wrong choice here. Most people we know who have had broken arms are able to care for most of their own needs once they are in a cast and out of the hospital. Sometimes they need the help of the family for a while, but the fact that Irene has no family does not change the medical picture. Go back to Item 50 and select another answer.

ITEM 52 (50b) Three cheers! You correctly recognized that all the conditions we mentioned were primarily custodial. The bathing, feeding, and vitamin giving requirements all could be met by nonmedical people. Go to Item 54.

ITEM 53 (50c) Please, now, you do not really mean it, do you? Sure, Mrs. Cooper needs someone to give her the spoonful of vitamins and to feed her; but you could do that, and chances are, you are not a licensed nurse. In fairness, we must congratulate you for realizing that the services Irene required because of her broken arm were simply custodial care. Now that you realize the services she received in the first 4-5 weeks were also custodial in nature, return to Item 50 and select the correct answer.

--HOME HEALTH BENEFITS--

PAGES 41 to 48

ITEM 54 So far we have learned that the hospital insurance program provides benefits for inpatient hospital services and post-hospital extended care. The third kind of benefits provided are for post-hospital home health services. Payments can be made for up to 100 visits by home health personnel during the 1-year period following the patient's latest discharge from a hospital or skilled nursing facility. To be eligible for home health benefits, the beneficiary must need either skilled nursing care on an intermittent basis, physical therapy or speech therapy; be homebound, and be under the care of a physician. In addition, the beneficiary would have to (1) have been an inpatient in a qualified hospital (whether or not it is participating in the program) for a medically necessary stay of at least 3 consecutive days, or have had a covered stay in a skilled nursing facility, and (2) have had a home health plan for care submitted in writing by a physician within 14 days after discharge.

Beneficiary Raymond Tucker spent 1 week in a hospital but received no benefits under Part A for inpatient hospital services because he had utilized all available benefit days in a previous stay. He was discharged on April 12, 1977. By April 21, Raymond's doctor had established a home health care plan for him. Which of the following statements is true?

a. Benefits payable for home health services are limited to 100 visits during the 1-year period following his discharge from the hospital. (See Item 55)

b. Benefits can be paid under the hospital insurance program for the first 100 visits of home health personnel following Raymond's discharge from the hospital. (See Item 56)

c. Raymond cannot receive benefits for services under Part A because he had not qualified for benefits during his most recent stay in the hospital. (See Item 57)

ITEM 55 (54a) You are absolutely correct. Benefits payable under the post-hospital home health care provision are limited to a maximum of 100 visits by home health agency personnel during the 1-year period following the patient's discharge from a qualifying stay in a hospital or skilled nursing facility. Raymond qualified for these benefits because he had been hospitalized for at least 3 days and the plan was established within 14 days of his discharge from the hospital. A beneficiary can qualify for home health benefits on the basis of a 3-day hospital stay (provided the stay was medically necessary) without having received inpatient hospital benefits, but cannot qualify on the basis of a stay in a skilled nursing facility unless it was a covered stay or would have been except the patient's extended care benefits had been exhausted. Go on to Item 58.

ITEM 56 (54b) Benefits can be paid for the first 100 visits of home health personnel, but only during the first year after a patient's latest discharge from a hospital or skilled nursing facility. Thus, the statement you choose would have been true only if the 1-year limitation had been included. As it stands, unqualified, the statement is false. Now return to Item 54 and choose another answer.

ITEM 57 (54c) It is not necessary to have received inpatient hospital benefits to receive home health benefits. If his days of coverage had not expired, Raymond would have normally received the hospital benefits. The fact that he spent at least 3 days in the hospital for a medically necessary condition means he can receive home health benefits. Return to Item 54 and select another answer.

ITEM 58 The 3-day length of stay requirement applies only to hospitals, not to skilled nursing facilities. If a beneficiary is to qualify for home health benefits following a stay in a skilled nursing facility, the only requirement is that the skilled nursing facility stay have been a covered one.

Sylvia Hanson had been receiving inpatient hospital benefits before her recent transfer to a skilled nursing facility, where she also received benefits under the hospital insurance program. After spending only 2 days in the skilled nursing facility, Sylvia was discharged to her home. Assuming that her doctor establishes a home health care plan within 14 days of her discharge from the skilled nursing facility, can Sylvia receive benefits for these home health services?

a. Yes. Sylvia would qualify because the plan was established within 14 days of her discharge from a covered stay in a skilled nursing facility. (See Item 59)

b. No. Sylvia would not qualify because, although her stay in the skilled nursing facility was a covered one, she had not remained a patient there for the minimum 3-day requirement. (See Item 60)

ITEM 59 (58a) Right you are! Sylvia would qualify because the plan of treatment was established within 14 days of her discharge from a covered stay in a skilled nursing facility. The requirement for a 3-day stay applies only to hospitals. When the home health services plan is established following a patient's stay in a skilled nursing facility, the only requirement is that the stay in the skilled nursing facility has been a covered one, i.e., the plan must be set up following a covered stay in a participating skilled nursing facility. Go on to Item 61.

ITEM 60 (58b) You say no? Remember, the 3-day requirement applies only to the hospital stay. A person must stay in a hospital for at least 3 days or have had a covered stay of any duration in a skilled nursing facility to be eligible for home health services. Thus, there is no minimum SNF stay requirement for home health benefits. Now return to Item 58 and choose another answer.

ITEM 61 Home health services are services furnished in a patient's home on a visiting basis by a participating home health agency. These services, which must be furnished under a plan established and supervised by a physician, include part-time nursing care, physical, speech or occupational therapy, medical social services, part-time home health aide services, and medical supplies and appliances. The patient may also receive home health benefits for services received on an outpatient basis at a hospital, skilled nursing facility, or rehabilitation center, if it is not practical to receive the services at home because it involves equipment which cannot be brought to the home, and the home health agency arranges for such services. The patient's transportation costs incurred traveling to a hospital outpatient department, skilled nursing facility, or rehabilitation center would not be covered.

Excluded from coverage under this provision are drugs and biologicals, physician's care, the cost of nonhealth-related items, such as "meals on wheels," maid services, and any item or service which would not be covered if furnished to an inpatient of a hospital.

Home health agencies, like hospitals and skilled nursing facilities, must meet certain requirements in order to participate in the Medicare program. Go on to Item 62.

--PSYCHIATRIC HOSPITALIZATION--

- o Reduction - 1st benefit period
- o 190-day lifetime limitation

--BLOOD DEDUCTIBLE--

--SOME EXCEPTIONS TO HI COVERAGE--

- o Nonparticipating hospitals
- o Foreign hospitals
- o Emergency hospital services
- o Christian Science sanitoriums
- o Federal hospitals

PAGES 49 to 72

ITEM 62 For a beneficiary in a participating psychiatric hospital on the first day of entitlement to hospital insurance, there is a special provision to reduce the number of days in the first benefit period. (This "reduction in days" provision relates only to hospitalization in a psychiatric hospital in the 150 days before first entitlement to hospital insurance benefits.) Each day a beneficiary was in a psychiatric hospital in the 150 days before first entitlement reduces by 1 day the number of days of hospitalization that can be received in a psychiatric hospital (or in a general hospital where a beneficiary gets psychiatric treatment) in the first benefit period.

Confused? Okay, let's take it step by step:

1. Count the number of days the beneficiary was in a psychiatric hospital in the 150 days prior to hospital insurance entitlement.

2. Subtract this number from 150.

3. This will give the number of days of psychiatric hospitalization the beneficiary can get in the first benefit period.

When George Evans became entitled to HI benefits, he was in a psychiatric hospital and had been there during 60 of the preceding 150 days. Thus, he can receive only 90 days of covered hospitalization for psychiatric treatment in his first benefit period. Let's assume George did, in fact, use up those 90 days of covered hospitalization for psychiatric treatment. No doubt you would immediately wonder what happens to the 60 days he "lost" due to the "reduction in days" provision. He could still use them, but only if he were hospitalized for other than mental or emotional illness in the same benefit period. For example, if he should fall and break his hip, up to 150 days of covered services in a general hospital would be available to him. Of course, the regular coinsurance and lifetime reserve provisions would apply.

Charlotte has been in a participating mental hospital continuously for 3 years. She is eligible for HI benefits in August of this year. Her condition has not responded to therapy.

a. Now that she is eligible, HI will pay for 150 days of psychiatric care, since she still needs active therapy and is not a custodial care patient. (See Item 63)

b. Her care in this hospital can be covered for 90 days, but the reduction in days provision eliminates the lifetime reserve days completely. (See Item 64)

c. She can receive no benefits for the care she receives for her mental illness because the reduction in days provision applies. (See Item 65)

ITEM 63 (62a) You have a generous heart, but we cannot go along with you. The law states that we must deduct any days of care in a psychiatric institution prior to the first month of HI entitlement. It is true that this provision is intended to prevent draining the trust funds to pay for custodial care, but we are not required to make a decision as to whether inpatient psychiatric care is custodial or not. All we need to know is when the patient attained eligibility, and how many days the patient was in a psychiatric hospital before the month of attainment. Return to Item 62 and choose another answer.

ITEM 64 (62b) Where did you get this idea? We did not say anything about losing only the lifetime reserve days. The reduction in days provision applies to all available days of HI coverage for hospitalization in a psychiatric institution for treatment or diagnosis of mental illness. Return to Item 62 and choose another answer.

ITEM 65 (62c) Absolutely correct! Charlotte may receive no Medicare payments for psychiatric hospital care after she became eligible because she was in the hospital in excess of 150 days.

However, if Charlotte later requires hospitalization for a condition other than mental illness, the regular 90-day and 60-day additional lifetime reserve provisions apply. Go on to Item 66.

ITEM 66 You have solved a problem concerning what happens when a patient has been in a psychiatric hospital for 150 days or more prior to entitlement to HI benefits. It is simple to understand since a patient loses all coverage under Medicare for similar treatment in that benefit period. However, the case where the patient has had less than 150 days in a psychiatric hospital is not so simple.

(continued on next page)

Let us consider a beneficiary who has been hospitalized in a participating psychiatric hospital for 40 of the 150 days just prior to the beneficiary's first day of entitlement to Part A, Hospital Insurance, and is still a patient in that hospital on the day entitlement begins. A beneficiary would still have some Medicare benefits available for a continued stay in that institution. (Remember, we said, "Each day in a psychiatric hospital in the 150 days before entitlement will reduce by 1 day the number of days of hospitalization a beneficiary can get for psychiatric care in a hospital in the beneficiary's first benefit period.") Just subtract the number of days the beneficiary was in the institution prior to the first day of entitlement; in this case, 150 - 40 = 110. The beneficiary would have the entire 90-day period left, plus 20 days of the lifetime reserve. Thus, the beneficiary could receive 110 days of covered services in a psychiatric hospital, 60 days fully covered (less the $180 deductible), 30 days with $45 per day coinsurance, and 20 days with $90 per day coinsurance. Just as in the previous example, the 40 days "lost" because of the reduction in days provision for psychiatric hospitals are still available in the same benefit period if the beneficiary, after 110 days in the psychiatric hospital, goes into a general hospital for treatment of a condition other than mental illness. These 40 days would then have to be drawn from the beneficiary's lifetime reserve days, with $90 daily coinsurance to be paid by the beneficiary.

Jack Sellers was confined to a psychiatric institution for diagnosis of a mental condition 55 days before his first entitlement to HI, and his treatment continued for an additional 65 days before he was released. Within 2 weeks of his discharge, he was severely burned in an auto accident, and spent 55 days in the County Hospital for intensive treatment. Select the statement below that gives the correct number of days of covered services available to him. The breakdown of coinsurance requirements is important to the correct answer.

a. Jack would receive 60 days of psychiatric treatment fully covered by HI, plus 5 days with a $45 per day coinsurance. Of course, the regular $180 deductible would apply. In the County Hospital, his first 25 days would be subject to the $45 coinsurance, since he is in the same benefit period. The remaining 30 days must come from the lifetime reserve, with $90 a day coinsurance. (See Item 67)

b. Mr. Sellers would be covered for all his psychiatric treatment after attainment. The first 5 days would be fully covered, subject to the $180 deductible. The next 30 days would be subject to the $45 coinsurance per day and the remaining 30 days would come from the lifetime reserve. In the County

Hospital, he would get 55 days' full coverage. Since he has 30 days of his lifetime reserve remaining, the cost of the last 10 days of treatment in the County Hospital will be covered subject to the $90 coinsurance. (See Item 68)

c. Jack would receive 60 days of psychiatric treatment fully covered by HI, plus 5 days with $45 per day coinsurance. Of course, the regular $180 deductible would apply. In the County Hospital, his first 25 days would be fully covered less the $180 deductible. The remaining 10 days would cost him $45 per day coinsurance, since this is in a different benefit period and a new 90-day period applies. (See Item 69)

ITEM 67 (66a) You have a good head on your shoulders! This is really a difficult problem but you successfully followed the example given in the narrative and applied the deductibles in all the right places. It is unlikely that you will be confronted by too many claims or inquiries concerning this reduction in days provision, but now that you have figured out how it works, you should have only one problem left to solve--that is, "how can I communicate this to someone else?" We have tried to communicate it by using a couple of examples. Perhaps you can think of a better way. Go on now to a new subject in Item 70.

ITEM 68 (66b) Apparently you either overlooked the hint we gave you in the paragraph preceding the problem or we did not present it clearly enough. We will assume it was our fault since this is a very difficult concept to explain. Can we put it more plainly? If some days are "lost" because of the reduction in days provision, they are lost from the end of the 150-day period--not from the beginning of the 90 days of full coverage. This means that the hospital days available for nonmental illnesses start where the others left off, whether it be in the lifetime reserve, the $45 coinsurance period, or in the first 60 days, up to the number that were affected by the reduction in days.

Example: George lost 15 days due to the reduction in days provision and remained in the psychiatric hospital 6 months before he was transferred to a general hospital for 3 weeks' intensive care to treat a peritonitis condition. He used 60 days of full coverage (less the $180 deductible), plus all his coinsurance coverage, including 45 days of the lifetime reserve during the 6 months in the psychiatric hospital. He still had 15 days of the lifetime reserve to apply towards the 3-week stay in the general hospital. Now return to Item 66 and select another answer.

ITEM 69 (66c) We caught you in a trap on this one. You correctly identified the conditions applying to the continued treatment in the psychiatric hospital, but you erred when you felt that an additional $180 deductible and new benefit period were involved here. It is true that Jack had a new illness, but not a new benefit period. The start of a new benefit period depends on how long the patient has been out of an institution, not on the condition for which the patient is being treated. Go back to Item 66 and try again.

ITEM 70 There is an additional deductible we haven't yet talked about, namely, "the blood deductible." This is equal to the cost of the first 3 pints of blood furnished a hospital or SNF inpatient during the beneficiary's benefit period. A similar provision applies to blood provided by physicians outside the hospital environment. This is the Part B blood deductible, and is discussed in detail in Medical Insurance Benefits. (However, the hospital or SNF cannot charge the patient for deductible blood if the patient arranges to have the 3 pints replaced.) A hospital or SNF can charge a patient its customary charge for unreplaced deductible blood, and the amount charged will be deducted from any payments made to the hospital under the hospital insurance program. (Only whole blood and equivalent units of packed red blood cells are subject to the blood deductible. One unit of packed red blood cells is equivalent to a pint of whole blood.) The intent of this provision is to encourage the voluntary replacement of blood.

Eric David qualified for inpatient hospital benefits. During his first stay in a hospital after becoming entitled, he is furnished 6 pints of blood which cost the hospital $30 each. The hospital usually charges its inpatients $50 for each pint of blood. Eric did not arrange to replace any of the blood.

Which of the following is true?

a. If the hospital charges Eric $50 per pint for the blood he must pay for himself, $150 will be deducted from the amount that hospital insurance would otherwise pay to the hospital for Eric's inpatient services. (See Item 71)

b. Since the hospital cannot make a profit on the blood for which it charges a patient, Eric will only have to pay $90 for the blood furnished to him. (See Item 72)

c. Eric will have to pay an additional $60 deductible to cover the cost of the first 3 pints of blood he is furnished. (See Item 73)

ITEM 71 (70a) This is true. Any amount charged a patient for unreplaced deductible blood is deducted from the amount of other benefits that would be paid to the hospital for inpatient services. Go on to Item 74.

ITEM 72 (70b) You believe that Eric will only have to pay $90 for the blood furnished him. This will not necessarily be true. The hospital can charge Eric up to its customary charge for his first 3 pints, and the amount of the charge will be deducted from any benefits otherwise payable to the hospital by the intermediary for Eric's inpatient services. Please return to Item 70 and choose another answer.

ITEM 73 (70c) While it is true that Eric will have to pay an additional deductible for the first 3 pints of blood furnished him during a benefit period, this is not a fixed dollar amount. Eric will have to pay up to the amount the hospital customarily charges for the first 3 pints of unreplaced deductible blood in a benefit period. Please return to Item 70 and choose another answer.

ITEM 74 So far, we have provided you with the general rules for determining when benefits will be paid under the hospital insurance program. Now we will discuss a few of the noteworthy exceptions. As you remember, we said that benefits could only be paid for services rendered by participating hospitals. Payments can also be made for emergency inpatient hospital services rendered by a nonparticipating hospital if the hospital agrees not to charge the patient for the same covered services, and if the hospital is the most accessible hospital equipped and available to provide emergency treatment.

In the event the nonparticipating hospital chooses not to accept Medicare payments for emergency services, the patient may request reimbursement subject to the inpatient hospital deductible and coinsurance. The patient receives 60 percent of the hospital's reasonable charge for routine services and 80 percent of the reasonable charge for ancillary services, (Ancillary services include X-rays, administration of anesthesia, use of the operating room, etc.) However, if the hospital involved is an all-inclusive rate facility, then reimbursement is 66 2/3 percent of the reasonable charge.

(A special provision for coverage of inpatient hospital services at foreign hospitals is that coverage is provided if: the eligible person is a resident of the United States, and such foreign hospital was closer or more accessible to the individual's residence than a U.S. hospital; or the beneficiary suffered a medical emergency in the U.S. or within Canada while traveling between Alaska and another State and the foreign hospital is closer or more accessible to the place the emergency occurred than the nearest adequately equipped U.S. hospital.)

Beneficiary Steve Foley is involved in an automobile accident and must be taken to the nearest hospital for emergency treatment. The hospital is not a participating hospital.

Assuming that this hospitalization begins a new benefit period, benefits could be paid for the cost, in excess of the $180 deductible, of the emergency inpatient hospital services that Steve receives if . . .

a. The hospital agrees not to charge Steve for covered services and is the most accessible hospital to the scene of the accident. (See Item 75)

b. The hospital had an agreement with the Secretary of Health, Education, and Welfare to furnish only emergency services. (See Item 76)

ITEM 75 (74a) Excellent! Emergency hospital services can be covered at nonparticipating hospitals as long as the hospital agrees not to charge the patient for the "same" covered services and is the most accessible hospital. Steve's hospital did meet these requirements. Now go on to Item 77.

ITEM 76 (74b) You believe that the hospital must have an agreement to furnish only emergency services. Actually, there is no such requirement. In some cases, payments will undoubtedly be made to strictly emergency hospitals. However, the main intent of this provision is to allow emergency services rendered by nonparticipating hospitals to be covered in certain instances. Please return to Item 74 and choose another answer.

ITEM 77 Inpatient hospital benefits can be paid for services received at Christian Science sanatoriums. These sanatoriums must be operated (or listed and certified) by the First Church of Christ Scientist in Boston, Massachusetts. Only the services which these sanatoriums would ordinarily provide their inpatients will be paid for.

In addition to the regular provisions for inpatient hospital care, the services rendered in a Christian Science sanatorium can be covered as skilled nursing facility services for an additional 30 days. Therefore, a patient, after incurring the $180 deductible, could receive up to 60 days of full coverage--30 days at the $45 daily coinsurance rate and 60 days of lifetime reserve at the $90 coinsurance rate, plus 30 additional days at the $22.50 daily SNF coinsurance rate. Thus, a total of 180 days may be provided for Christian Science sanatorium inpatients. The regular 100-day provision of SNF services does not apply to treatment in Christian Science sanatoriums; payment for extended care services in the Chrisitian Science sanatoriums may not be made for more than 30 days in each benefit period.

There are special exceptions to these general rules when the patient is treated in both regular medical facilities and Christian Science sanatoriums. When a question arises on this topic, you should consult appropriate manuals for guidance. Go to Item 78.

ITEM 78 As we have learned already, the hospital insurance program will pay benefits for inpatient hospital services at general hospitals and Christian Science sanatoriums for 90 days in each benefit period plus 60 days' additional lifetime reserve. The same benefits apply to patients of participating tuberculosis hospitals. We have also learned that patients in a psychiatric hospital (or in a general hospital for treatment or diagnosis of mental illness) are subject to a special "limitation of days" provision if they are in a psychiatric hospital on the first day of their entitlement to hospital insurance benefits.

There is also a 190-day lifetime limit on covered inpatient services in psychiatric hospitals. Coverage will not be provided at psychiatric hospitals for more than this number of days during the lifetime of any one person. This lifetime limit is not affected by application of the reduction in days provision.

Beneficiary Doris Rhodes has been in and out of private psychiatric hospitals since her husband died and left her a widow at age 67 with no other kin. She entered the hospital the last time on January 3, 1980, and was discharged on April 6, 1980. Before that she had 3 confinements of 10 days each, all covered by Medicare, in different benefit periods. Doris enters the psychiatric hospital again on July 15, 1980, for a 6-month course of treatment. What will be her last date of covered psychiatric hospital services.

a. September 20, 1980. (See Item 79)

b. October 12, 1980. (See Item 80)

c. September 19, 1980. (See Item 81)

ITEM 79 (78a) Well you almost got it. You correctly figured the total days that Doris has spent in the psychiatric hospital.* You then figured that there were 67 days left in the 190-day lifetime limit on covered psychiatric hospitalization.** Next, you probably made this calculation: July 15, 1980 = 196 + 67 = 263 = September 20, 1980. Although this seems right, it won't work because July 15 must be counted as one of the 67 additional days of coverage. By adding 67, you have, in effect, counted July 15 twice. Now go back, reread Item 78, then select the correct answer.

* January 3, 1980 = Julian date 003; April 6, 1980 = 096; 96 minus 3 = 93 days, plus 30 days' prior confinement = 123

** 190 minus 123 = 67

ITEM 80 (78b) Think again. Although Doris is in a new benefit period, she does not have 90 days of psychiatric care still coming to her because of the 190-day lifetime limitation on services in psychiatric hospitals for the treatment or diagnosis of mental illness. If there were no limitation, your answer would still be wrong, since she has some days left from her lifetime reserve. Return to Item 78, reread the entire item, and then select the correct answer.

ITEM 81 (78c) If you got the correct answer here, you are to be congratulated. This one is a bit tricky. You correctly figured the total days that Doris spent in the psychiatric hospital.* You then figured that there were 67 days left in the 190-day lifetime limit on covered psychiatric hospitalization.** The crowning touch was your accurate use of the Julian calendar to determine the last day of coverage.***

* January 3, 1980 = Julian date 003; April 6, 1980 = 096; 96 minus 3 = 93 days, plus 30 days' prior confinement = 123;

** 190 minus 123 = 67;

*** July 15, 1980 = 196 + 66 = 262 = September 19, 1980.

(Since there are 67 days of covered inpatient psychiatric care remaining, and Doris entered the hospital on July 15, you must count July 15 as one of the days. Therefore, in using the Julian calendar to determine the last date of covered psychiatric services, you must add 66--not 67--days.)

Go on to Item 82.

ITEM 82 Just as general hospitals must meet certain requirements in order to be considered participating hospitals, psychiatric hospitals must meet certain conditions to be considered participating psychiatric hospitals.

Go on to Item 83.

ITEM 83 No payment can be made for services furnished by Federal providers (except for emergency services and services furnished by Federal hospitals that serve as community hospitals).

Which choice below contains only hospitals in which ordinary inpatient services cannot be covered? (Emergency services are payable in any of them.)

a. Tuberculosis hospitals, Federal hospitals. (See Item 84)

b. Federal hospitals, nonparticipating hospitals. (See Item 85)

c. Psychiatric hospitals, participating hospitals. (See Item 86)

ITEM 84 (83a) Although inpatient services furnished by Federal hospitals are usually not covered by the hospital insurance program, those furnished by tuberculosis hospitals are covered. Now go back to Item 83 and choose another answer.

ITEM 85 (83b) Right! Benefits cannot be paid for services furnished to inpatients of Federal hospitals or nonparticipating hospitals. (Now use your mask again to continue with the text.)

ITEM 86 (83c) Hold it! Benefits can be paid for services furnished by participating hospitals and by psychiatric hospitals. The only restriction with respect to psychiatric hospitals is for benefits furnished to persons who first become entitled to benefits while they are in the hospital or for persons who have already had 190 days of covered services in psychiatric hospitals. Now go back to Item 83 and choose another answer.

We have learned that the hospital insurance program provides protection against the cost of covered inpatient _____ services.	hospital
Some of the services covered are: 1. Room and board in semi-_____ accommodations; 2. Routine _____ care; and 3. Drugs furnished by the hospital.	private nursing
Which of the following is not specifically excluded from coverage as inpatient hospital services: 1. Physicians' services 2. Private duty nursing 3. Laboratory tests.	3. Laboratory Tests
Benefits will be provided for inpatient hospital services for up to _____ (how many) days in each benefit period, besides lifetime reserve days.	90
In addition to the 90 days in each benefit period, benefits are provided for inpatient hospital services for a lifetime reserve of _____ days.	60

However, for benefit periods beginning in 1980, the patient is responsible for a $_____ deductible amount and must also meet a deductible for the cost of the first _____ (how many) pints of blood received.	$180 3
The patient must also pay a daily coinsurance equal to _____ (fraction) of the inpatient hospital deductible for the last 30 days of the 90-day period.	1/4
This daily coinsurance is $_____ per day and the daily coinsurance for the 60 additional lifetime reserve days is $_____.	$45 $90
A benefit period ends when the patient has not been an inpatient of any hospital or skilled nursing facility for _____ consecutive days. The 60-day period begins with the day of _____.	60 discharge
The hospital insurance program also provides coverage for post-hospital _____ care services.	extended

Covered extended care services are those ordinarily provided by skilled nursing facilities to their patients. Generally, these will be semi-private room and board, nursing care, physical therapy, and drugs. True or False? _____	True
However, in no case can payment be made for any extended care service, drug, or other item which could not be paid for under the hospital insurance program if furnished in a _____.	hospital
To be eligible for extended care benefits, a patient must first have a qualifying stay of at least _____ consecutive days in a hospital and be transferred to a participating skilled nursing facility generally within _____ days of discharge. NOTE: It should be remembered that the 14-day transfer requirement can be extended in certain cases. For example, this may occur when a patient's transfer to a SNF is delayed because no bed space is available in that geographic area.	3 14
Services of a skilled nursing facility are covered for up to _____ days in each benefit period.	100
For each day over the first 20 days that a patient received covered services in a skilled nursing facility, the patient must pay a coinsurance equal to _____ (fraction) of the inpatient hospital deductible.	1/8

This coinsurance amount is $_____ for benefit periods beginning in 1980.	$22.50
Skilled nursing facilities also have to meet certain requirements to be eligible to participate in the _____ _____ program.	hospital insurance
A third type of benefit provided under the hospital insurance program is for post-hospital _____ health services.	home
Under this provision, payments would be made for up to _____ visits of home health agency personnel. (how many)	100
Payments under Part A are limited, however, to the _____ year period following the patient's late discharge from a qualifying stay in a hospital or skilled nursing facility, or until the beginning of a new benefit period, whichever is earlier.	1

To be eligible for Part A home health benefits, the patient would have to have been an inpatient in a hospital for at least _____ consecutive days, or . . .	3
have had a covered stay in a _____ _____ facility.	skilled nursing
The home health plan would also have to be developed and supervised by a _____.	physician
And plans would have to be reduced to writing within _____ days of the patient's discharge from the hospital or skilled nursing facility.	14
Benefits are paid for services furnished in a patient's home on a visiting basis by a participating home _____ _____.	health agency

These services may include: 1. _____-time nursing care; 2. Certain rehabilitative _____; and 3. Medical social services.	part therapy
Specifically excluded from coverage under this provision are: 1. _____ and biologicals; 2. Physicians' care; and 3. _____-related items.	drugs Nonhealth
Inpatient hospital benefits for services at Christian Science sanatoriums will be provided for a total of _____ (how many) days in each benefit period plus _____ (how many) lifetime reserve days.	90, 60
Thirty (30) additional days in each benefit period are covered as _____ _____ services.	extended care
For these 30 days, the patient must pay a coinsurance amount of $ _____ per day.	$22.50

Benefit payment for inpatient psychiatric hospital services will be made for most services that psychiatric hospitals furnish their inpatients, with the exception of _____ care.	custodial
If a patient is in a psychiatric hospital on the first day they are entitled to benefits, the days they have been in such a hospital during the 150 days immediately preceding that day _____ count against the 90-day limit (would, would not) and also against the 60-day lifetime reserve days, but only for inpatient hospital services for psychiatric care received during that benefit period.	would
There is a _____-day lifetime limit on coverage of inpatient psychiatric hospital care.	190
Any days subtracted from the 90-day and 60-day limits in the first benefit period of a psychiatric hospital inpatient _____ also be subtracted from the (will, will not) patient's 190-day lifetime limit.	will not
Psychiatric hospital inpatients are, of course, subject to the $ _____ deductible for each benefit period . . .	$180

and the $ _____ daily coinsurance for the last 30 days of the 90-day period . . .	$45
plus the $ _____ daily coinsurance for any of the 60 lifetime reserve days used.	$90
Payments cannot be made for services furnished by a Federal hospital, except for necessary _____ services, or unless the Federal hospital serves as a _____ hospital.	emergency community
Now go on to the next page, read the material presented, select one of the given answers, and turn to the Item corresponding to the answer you select. You do not have to use the mask for a while now.	

--LEVEL OF CARE--

--WAIVER OF LIABILITY--

PAGES 73 to 90

ITEM 1 An area in which the Medicare program encounters a great deal of misunderstanding is in the concept of "level of care." This is perhaps the most misunderstood of all the provisions of the Medicare Act. A general understanding of what is meant by "level of care" is necessary in order to answer the questions of beneficiaries, their representatives, and the public in general.

The term "level of care" relates to the type and amount of care which must be both needed by and provided to Medicare beneficiaries, either as inpatients of a hospital or skilled nursing facility or as homebound beneficiaries receiving care from a home health agency, in order for Medicare to cover the services rendered. For each of these three categories of providers, there are certain types of care which must be needed by the patient and provided by the provider of services to satisfy criteria for a determination that a "covered level of care" was rendered. The level of required care is different for each of the three types of services--inpatient hospital, extended care, and home health. To state this "level of care" concept another way: for Medicare reimbursement to be made, both the type of provider and the care provided to the beneficiary must be appropriate to the beneficiary's medical needs.

Which of the statements below is true?

a. "Level of care" is a term used only in relation to care provided to Medicare beneficiaries in skilled nursing facilities. (See Item 2)

b. "Level of care" is a term describing care as it applies in each of the major benefit provisions of the hospital insurance program. (See Item 3)

ITEM 2 (1a) Not true. Though most of the controversial and borderline cases are concerned with extended care, the term "level of care" applies to inpatient hospital care and home health care also.

ITEM 3 (1b) Very good. The term "level of care" describes the extent of care required for Medicare payment to be made, whether a beneficiary is receiving inpatient hospital services, skilled nursing facility services, or services from a home health agency. Go on to Item 4.

ITEM 4 The level of care criteria for inpatient hospital benefits is probably best viewed in light of the type of patient served. The type of patient the inpatient hospital benefit is intended to serve is one whose condition requires:

1. direct and frequent physician involvement, and/or

2. continuing use of the complex medical equipment and services generally found only in a hospital setting.

If this is not the case (i.e., if the patient's condition is not of this severity) and the care needed could be provided in a less intensive setting or on an outpatient basis, the patient does not meet Medicare's level of care requirement for inpatient hospital benefits.

Eugene Hughes was admitted to Freeland Hospital on March 15, 1980, for medically necessary treatment. He progressed very nicely and was ready to be discharged on April 2, 1980. Since Eugene did not require subsequent extended care services, he had planned to recuperate at home under the watchful eye of his daughter who was coming from her home 1,500 miles away to be with him. However, his daughter was delayed and was not able to begin caring for him until April 6, 1980. Could Eugene have remained in the hospital until April 6, 1980, and continued to be reimbursed under the hospital insurance program?

a. Yes. (See Item 5)

b. No. (See Item 6)

ITEM 5 (4a) Eugene may have remained in the hospital until April 6, 1980, when his daughter would have been able to care for him, but he could not have been reimbursed by the hospital insurance program all the way up to that date. As of April 2, 1980, he no longer required the level of care necessary for reimbursement for inpatient hospital benefits. If you answered yes, you need a better understanding of "level of care" as it applies to hospitals. Return to Item 4 and read again.

ITEM 6 (4b) Correct. Eugene could not have received inpatient hospital benefits after April 2, 1980, because his condition after that date was no longer of a severity requiring the continuing attention of physicians and availability of the complex medical equipment and services generally found only in the hospital setting. Go on to Item 7.

ITEM 7 At times there are problems relocating patients who no longer require the level of care that can only be provided by a hospital, but who require instead further treatment that could appropriately be provided in a skilled nursing facility. In these instances, when the beneficiary remains a hospital inpatient awaiting transfer to a skilled nursing facility, a special provision can permit Medicare to continue hospital benefits even though the beneficiary no longer needs a hospital level of care. Essentially, this provision states that in the event a patient who is eligible for posthospital extended care

--no longer requires inpatient hospital care, but

--does require a skilled nursing facility level of care, and

--cannot be transferred because there is no skilled nursing facility bed available,

Part A coverage for inpatient hospital care can continue until

--benefits are exhausted, or

--the patient no longer needs the skilled nursing facility level of care, or

--a skilled nursing facility bed becomes available.

Which of the statements below is true?

a. If a beneficiary no longer needs the level of care that can only be provided by a hospital but is awaiting transfer to a nursing home, the hospital insurance program will continue hospital benefits if a nursing home bed is unavailable and the beneficiary's doctor documents the facts. (See Item 8)

b. Inpatient hospital benefits can continue for an inpatient even though the patient's condition no longer requires that level of care, if the patient needs a covered level of SNF extended care but no skilled nursing facility bed is available. (See Item 9)

c. If a patient no longer requires inpatient hospital care but does require home health care, the patient can continue to receive inpatient hospital benefits until arrangements can be made with a home health agency (HHA). (See Item 10)

ITEM 8 (7a) A nursing home is different from a skilled nursing facility. No payment can be made for a continued hospital stay which is due to the lack of a nursing home bed.

ITEM 9 (7b) That's right. Inpatient hospital benefits can continue for a beneficiary even though the beneficiary's condition has improved to the point where a hospital level of care is no longer required. A special provision under Medicare states that if the above is the case and the patient requires a covered level of SNF care and there is no SNF bed available, Part A hospital benefits can continue until such time as benefits are exhausted, or the patient no longer needs a covered level of SNF care, or a SNF bed becomes available. Go on to Item 11.

ITEM 10 (7c) Hold on. You have made an assumption that the special provision under Medicare applies also to home health benefits. It does not. The only latitude that is allowed is with reference to the hospital inpatient awaiting transfer to a skilled nursing facility. Return to Item 7 and select another answer.

ITEM 11 Now let's move on to "level of care" as it relates to skilled nursing facilities. It is complex but bear with us.

> Posthospital extended care services are covered where an individual needs, on a daily basis, skilled nursing or other skilled rehabilitation services which
>
> --as a practical matter can only be provided in a SNF on an inpatient basis, and
>
> --are for the continued treatment of a condition for which the individual received inpatient hospital services (or for the treatment of a condition that arose while the individual was in a SNF receiving care for a condition for which the individual had received inpatient hospital services).

Decisions to approve or deny reimbursement under Medicare based on interpretations of the above definition have been the source of considerable debate. We will attempt to give you some insight into the difficulties involved in making these determinations in order to provide you with a better understanding of level of care as it applies to SNF's.

Skilled care versus supportive (or custodial) care is often at the heart of level of care determinations. Some of the distinctions are outlined in the following list, which is by no means exhaustive:

Skilled Services	Supportive/Custodial Services
1. Intravenous feedings (feeding through the veins) and intravenous therapy.	1. Administration of routine oral medications, eye drops, and ointments.
2. Catheter insertion or replacements, and sterile irrigation of a catheter.	2. General methods of treating incontinence, including use of diapers and rubber sheets.
3. Application of dressings involving prescription medicines or aseptic techniques.	3. Changes of dressings in non-infected post-operative or chronic conditions.
4. Care of extensive decubitus ulcers (bedsores) or other widespread skin disorders.	4. General supervision of exercises the patient has been taught to do.
	5. Assistance in dressing, eating, and going to the bathroom.
	6. Bathing, application of creams and other similar treatment of skin problems.

George Heyman suffered a fall in which he was hospitalized 5 days. He was transferred to a SNF within 14 days of his discharge. His doctor stated that he would need the type of care provided in the SNF, otherwise he would develop painful bedsores and need to be rehospitalized. Would the care that George needed be skilled or supportive?

a. Skilled care. (See Item 12)

b. Supportive or custodial care. (See Item 13)

ITEM 12 (11a) You say that the type of care George needed was skilled care. It is true that care of already existing extensive bedsores is a skilled service, but in George's case, his doctor admitted him to the SNF to prevent bedsores. This type of care could be provided by unskilled aides, or even by relatives at home, and would therefore probably be considered supportive care. Now read Item 13 below.

ITEM 13 (11b) Congratulations! You have recognized that George did not have the bedsore condition prior to admission to the SNF, and you have also recognized that care to prevent the bedsores is supportive rather than skilled nursing care. Go on to Item 14.

ITEM 14 After suffering second-degree burns and spending 3 weeks in the hospital, Joe Wellman was admitted to the Greystone Nursing Center, a participating skilled nursing facility. Joe's treatment plan included daily dressing changes with careful application of prescribed ointment to infected burned areas. In addition he needed close observation. Joe had no living relatives to assist him at home. What level of care determination would probably be made in this case?

a. Not reimbursable under extended care benefits. The fact that Joe had no living relatives is irrelevant. A home health agency could arrange for intermittent visits by HHA personnel to care for Joe's dressings. (See Item 15)

b. Joe's care and need is of sufficient level to require covered extended care services. (See Item 16)

c. Not reimbursable under extended care benefits. The care is supportive rather than skilled. (See Item 17)

ITEM 15 (14a) You have analyzed this case quite well, and you have correctly recognized that factors such as having no living relatives would not enter into a coverage decision. However, Joe's condition requires skilled services on a daily basis, along with close observation--not intermittent or part-time nursing services. As a practical matter, these skilled services could be furnished only in a SNF. Go back to Item 14 and select another answer.

ITEM 16 (14b) Good. You have recognized that Joe has a need for skilled nursing care on a daily basis (dressing changes with prescription ointment applications) which, as a practical matter, could only be furnished in a SNF because close skilled observation is also needed. The daily and continuing skilled observation factor would not be feasible via home health services. Go on to Item 18.

ITEM 17 (14c) Perhaps you are being hasty. It is true that simple changes of dressing are supportive services, but dressing care where ointment on infected areas is required constitutes skilled care. When it is needed daily and combined with close skilled observation, Joe probably is in need of a level of care reimbursable by Medicare for SNF services under the hospital insurance program. Return to Item 14 and try again.

ITEM 18 Level of care determinations can be tricky and hinge sometimes only on the "turn of a word." Fortunately, you will not have to make these decisions yourself, but you should understand something about the theory. For example, you recall that the SNF level of care requirement is, among other things, that the individual must need the care. You will see how this applies in the next situation.

Henry Pitts filed an appeal because he was denied coverage for the first 21 days of a 35-day stay in the Scenic View SNF. Henry had a stroke and was hospitalized for 8 days, then immediately transferred to Scenic View SNF. His doctor submitted a plan stating that Henry needed physical therapy on a daily basis to restore movement to a paralyzed limb, but that treatment should not start until 3 weeks had elapsed from the time of hospital discharge to give the leg time to be restored. No further treatment was recommended for Henry. Henry felt that even though he needed no treatment during the first 3 weeks the full stay should be reimbursed, since he had been hospitalized for over 3 days and admitted to the SNF within 14 days of discharge for further treatment of the same condition. Is he right?

a. Yes. (See Item 19)

b. No. (See Item 20)

ITEM 19 (18a) On the surface you might seem justified in saying so. After all, Henry was hospitalized for over 3 days and admitted to the SNF within 14 days of discharge. He was admitted for further treatment of a condition for which he had been hospitalized. All services of the SNF were available during the full period of admission. All the conditions are present except one: Henry didn't need the SNF care during the first 3 weeks in the SNF. Read the correct answer below, Item 20.

ITEM 20 (18b) No is the correct answer. If Henry is admitted to a participating SNF within 14 days after discharge from a hospital, but it was medically predictable that he would not need the required level of skilled care until more than 14 days had elapsed, the service would not be covered until such time as it was medically appropriate to begin an active course of treatment requiring a SNF level of care. To provide otherwise would mean that Henry would automatically be entitled to payment for SNF care becase he was admitted within 14 days, even though the care was custodial during part of that time. Remember, we said earlier in this text that, under certain conditions, a period longer than 14 days may be permitted before admission to a SNF. This is one of those circumstances. Since Henry was awaiting a certain degree of improvement in his condition before he would need the services of a SNF, he could have been admitted to the SNF later than 14 days from his hospital discharge and still have his SNF services covered.

ITEM 21 A "covered level of care" for home health services is similar to a "covered level of care" under the extended care provision; i.e., skilled care, as opposed to supportive or custodial care, must be both required and provided. Presently the Medicare law limits home health benefits to those beneficiaries who are confined to their homes, under the care of a physician, and in need of skilled nursing care on an intermittent basis or physical or speech therapy. In addition, Medicare will not pay for items or services which are not reasonable and necessary to the treatment of the beneficiary's illness or injury.

For this discussion on home health benefits, we will concentrate on level of care determinations involving skilled nursing care rather than those involving physical or speech therapy, since skilled nursing care is the issue more often encountered. "Skilled nursing care" is defined as services which can be carried out safely and effectively only by, or under the direct supervision of, a licensed nurse. If a service can be adequately and safely performed by the average nonmedical person, it is not a skilled service for Medicare purposes even if it is performed by a licensed nurse.

Which of the situations below involving nursing care provided to homebound beneficiaries would most likely describe covered level of care under the Medicare home health benefit provision? Assume that all other necessary requirements are met for home health benefit eligibility.

a. Irene Baldwin, after cataract surgery and post-operative stay in the hospital, is discharged to her home. She requires daily applications of eye drops and ointment and is unable to apply these medications herself. Arrangements were made for a registered nurse to come in and do this for her. (See Item 22)

b. Ronald Naber had surgery for a hernia and was discharged from the hospital to his home earlier than usual in such cases. Although his doctor felt he was well enough to go home, there was still a high likelihood of complications arising during his postoperative period. For this reason, arrangements were made for a registered nurse to visit twice a week to check on Mr. Naber's progress. (See Item 23)

c. Doris Meeker spent 2 weeks in a SNF and was then released to her home. She was blind and arrangements were made to have a nursing aide come in and administer medications (under the supervision of a physician) since the medicine, if taken incorrectly, could be harmful to Mrs. Meeker. (See Item 24)

ITEM 22 (21a) Not this one. Although Irene cannot administer the medications herself, the services of a licensed nurse are not required. With brief instructions, these medications could easily be administered by a nonmedical person. Return to Item 21 and select another situation.

ITEM 23 (21b) Correct. The level of care required by Mr. Naber is sufficient for home health benefits because he is in a postoperative period during which complications may arise which would require the expertise of a licensed nurse to recognize. Go on to Item 25.

ITEM 24 (21c) Mrs. Meeker's situation is one in which she definitely needs assistance; however, the services that she requires do not constitute skilled nursing care. This care can be administered by any friend or relative, with some instruction by a physician or nurse. Return to Item 21 and select another situation.

ITEM 25 A discussion on level of care is a natural lead-in to the "waiver of liability" provision of Medicare. There are times when a beneficiary accepts provider services in good faith, believing them to be covered by Medicare, only to find out later that they are not--for one of two reasons: either the services are determined to constitute custodial care, or they are determined not to be "reasonable and necessary." The Medicare program recognizes that it is unfair in such cases to leave the beneficiary (or at times the provider) "holding the bag" for the services already rendered. The waiver of liability provision grants relief in certain of these situations. It provides that the beneficiary will not be held liable for payment if the beneficiary did not know (nor could reasonably be expected to have known) that the services provided were not covered. The Medicare program itself will assume liability if neither the beneficiary nor the provider knew (or could reasonably be expected to have known) that the services were not covered.

Where would liability be likely to reside in the following situation?

Irene Holton was admitted to a participating SNF after a qualifying hospital stay, and services were rendered for the care of a condition that seemed to fit the level of care criteria for SNF's. When Irene was first admitted to the SNF, there was no indication that the services she required would not be covered. However, on a subsequent review of the facts, the intermediary determined that no part of the SNF stay was covered, and both the beneficiary and the provider were notified of this determination.

a. With the beneficiary. (See Item 26)

b. With the provider. (See Item 27)

c. With Medicare. (See Item 28)

ITEM 26 (25a) You think the beneficiary is liable? This is unlikely since initial indications were that services would be covered. Mrs. Holton could not reasonably have been expected to know that this judgment would be reversed. Return to Item 25 and select another answer.

ITEM 27 (25b) Perhaps the provider should have known that the services were not covered since the provider is expected to know the kinds of services covered under Medicare. However, the provider had been given no indication that this type of stay would be considered noncovered. Thus, in the absence of evidence to the contrary, the provider would not be held liable. Go back to Item 25 and select another answer.

ITEM 28 (25c) Right. Barring any evidence to the contrary, it would seem that neither the beneficiary nor the provider knew the services were not covered, nor could either reasonably have been expected to know.

ITEM 29 The waiver of liability provision applies to Part A denials with respect to:

1. Items or services that are not reasonable and necessary for the diagnosis or treatment of an illness, injury, or to improve the functioning of a malformed body part;

2. Items or services that constitute custodial care.

The waiver of liability provision does not apply to claims denied for any other reason.

There are some types of denials that specifically cannot involve the waiver of liability provision. The following are some (but not all) examples:

1. Inpatient hospital services for noncovered dental care, cosmetic surgery, or excluded foot care services.

2. HHA services denied because the patient is not homebound.

3. SNF stay not preceded by the required 3-day hospital stay.

4. Denial of charges for private room accommodations.

Place a check mark in the space next to the type of denial which specifically cannot be subject to the waiver of liability provision of the Medicare law. See Item 30 for correct answers.

_____a. Beneficiary is denied SNF benefits because the beneficiary's physician admitted the beneficiary directly from home. The beneficiary had never been hospitalized before.

_____b. Benefits are denied to a beneficiary hospitalized for a facelift.

_____c. Denial of benefits to a beneficiary receiving HHA services who was discovered spending 6 hours daily at the racetrack.

_____d. Benefits are denied to a hospital inpatient for the last 5 days of an inpatient stay because the beneficiary required only a custodial level of care during those days prior to discharge.

ITEM 30 Answers to Item 29 (numbers in parentheses refer to the type of denial as listed in Item 29 on preceding page):

a. (3)

b. (1)

c. (2)

ITEM 31 While we do not want to get into all the complexities of this difficult provision, we do want to give you a simple description of what happens in waiver of liability situations. After a determination has been made to deny benefits for reasons subject to this provision (i.e., services are not reasonable and necessary or which constitute custodial care), the intermediary reviews the evidence in each case to determine whether the beneficiary should be found liable. Unless evidence shows the beneficiary knew (or could reasonably have been expected to know) that the beneficiary received noncovered services, the beneficiary is presumed not to have known, and thus not to be liable.

Some examples of evidence indicating that the beneficiary should have known are:

1. A written notice from the provider that services were not covered.

2. A denial letter for similar noncovered services in the past.

Although these are reasons supporting a determination that the beneficiary should have known that the services were not covered, neither, by itself, constitutes absolute knowledge on the part of the beneficiary. All the evidence held by the intermediary must be examined to determine whether or not the beneficiary is liable for the services in question.

ITEM 32 As in the case of a beneficiary, the provider, in the absence of evidence to the contrary, may be presumed not to have known (and not reasonably expected to have known) that services provided were not covered. Some examples of evidence to the contrary may be that the provider had received denials in the past on similar cases; or that the utilization review committee had informed the provider that the services in question were not covered. In such cases, the provider may be found liable by the intermediary.

TAKE YOUR MASK AND CONTINUE WITH THE TEXT.

The need for <u>continuing</u> attention of skilled medical personnel, and ready availability of physicians and complex medical equipment and services, is the <u>level of care</u> required for Medicare payment to _____. (which type of provider?)	hospitals
There is a special provision under Medicare in which a beneficiary in a hospital, but no longer needing that level of care, can continue to receive inpatient hospital benefits. True or False?	True. (The beneficiary must require care that would represent covered SNF care and there is no SNF bed available.)
One of the "level of care" requirements for coverage in a SNF is that the patient's condition required "skilled nursing care or other skilled rehabilitation services on a daily basis." True of False?	True.
Mark the following examples of SNF care as skilled or custodial by using the letters "S" or "C." 1. Assistance in dressing, eating, and going to the bathroom. 1. _____ 2. Intravenous feeding. 2. _____ 3. Care of extensive bedsore ulcers. 3. _____ 4. General supervision of exercises. 4. _____	1. C 2. S 3. S 4. C
The level of skilled nursing care for home health benefits requires that the beneficiary need the services on a daily basis. True of False?	False. (Skilled nursing care need only be required on an intermittent basis.)

In waiver of liability cases, if neither the beneficiary nor the provider knew (or could reasonably have been expected to know) that items or services were not covered, or that care was custodial, the _____ program assumes liability for payment.	Medicare
Which denials of coverage in the list below may be applicable to the waiver of liability provision? Denials for: a. Removal of a mole for cosmetic purposes as inpatient hospital treatment. b. Nonqualifying hospital stay prior to SNF stay. c. Supportive or custodial care in a general hospital. d. HHA services because patient not homebound. e. Private room accommodations in a SNF.	c.

- INTERMEDIARY FUNCTIONS -

- REASONABLE COST -

- NON-INTERFERENCE IN PRACTICE OF MEDICINE -

- TITLE VI -

- HEARINGS & APPEALS -

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ITEM 1 Up to this point, we have been saying, "patients will receive benefits . . ." and "persons receiving benefits for covered services . . ." and so on. Actually, the beneficiary will only "receive benefits" in the sense that the beneficiary will benefit under the HI program. Benefit payments for Part A covered services will be made directly to the providers of services. Providers of services, of course, are hospitals, skilled nursing facilities, and home health agencies. (For purposes of outpatient physical therapy and speech pathology services, a provider of services may also be a clinic, rehabilitation agency, or public health agency.)

Irene Sloan received covered inpatient services from General Hospital. Irene had to pay the hospital the $180 deductible for the inpatient services she received. Medicare covered the remaining $385.

Which of the following is true?

a. The $385 benefit payment will be made to Irene, who is then responsible for turning the money over to the hospital along with her $180 deductible. (See Item 2)

b. The $385 benefit payment will be made to General Hospital. (See Item 3)

ITEM 2 (1a) You believe that Irene will receive the $385 benefit payment for the covered services she receives. This is not the case. Individual beneficiaries will not receive any benefit payments under Part A for hospital insurance (except under certain conditions, when emergency services are involved and the hospital refuses to bill the program). Instead, the benefit will be made directly to the provider of services. The covered services that Irene received were provided by General Hospital, and General Hospital will receive the benefit payment. Please turn to Item 1 and choose another answer.

ITEM 3 (1b) Right you are! General Hospital was the provider of services, and benefit payments for inpatient services are made to providers of services. Go on to Item 4.

ITEM 4 As you remember, each of the different kinds of providers of services--hospitals, skilled nursing facilities, and home health agencies--must meet certain requirements pertaining to their purpose, organization and operations to be eligible for participation in the HI program. One requirement is that no provider of services can discriminate because of race, color, or national origin. This requirement comes from Title VI of the Civil Rights Act of 1964 and will be referred to from here on as Title VI. Its goal is to ensure that all beneficiaries will have equal access to all appropriate facilities and will receive equal treatment. The Public Health Service (PHS) has been assigned the responsibility for determining whether providers are in compliance with Title VI. Social Security offices often serve as information channels to route complaints of discrimination against providers directly to PHS, but do not become involved in decisions as to whether the complaints are justified.

A Social Security beneficiary calls at the Social Security office. The beneficiary tells you of being refused admission to a local participating hospital. The beneficiary feels very strongly that this refusal was due to the beneficiary's origin. The correct action to take would be to:

a. Ask the district manager to contact the hospital, explain Title VI, and attempt to resolve the complaint. (See Item 5)

b. Tell the claimant that hospitals are private institutions and as such they can admit or refuse admittance as they see fit. (See Item 6)

c. Tell the claimant that the complaint will be referred to PHS, and make no attempt to resolve the complaint. (See Item 7)

ITEM 5 (4a) The district manager should contact the hospital? Be careful; remember that the Social Security office is not to become involved in resolving the issue, since PHS has responsibility for determining compliance. Please return to Item 4 and choose another answer.

ITEM 6 (4b) The hospital may or may not be a private institution, but its participation in the Medicare program requires compliance with Title VI. Since Title VI bars discrimination, can't something be done? Please return to Item 4 and choose another answer.

ITEM 7 (4c) Right! PHS has the responsibility for determining compliance, with the Social Security office serving as the channel for routing the complaint.

ITEM 8 The decision as to whether to file a complaint is the responsibility of the claimant, and PHS will determine compliance. The interviewer in the Social Security office, however, should furnish any program information that might help clear up misunderstandings regarding what benefits are provided under Medicare.

A claimant called at the Social Security office and stated that City Hospital said the claimant would have to pay the surgeon's (private practice) fee. The claimant believes this is discrimination because of the claimant's race. The Social Security office should:

a. Record the complaint and indicate the claimant will be advised of the outcome by PHS. (See Item 9)

b. Explain that the surgeon's fees are not covered under Part A (though they may be covered under Part B) and, therefore, the claimant should not file a complaint. (See Item 10)

c. Explain that the surgeon's fees are not covered under Part A, but leave it to the claimant to decide whether or not to file a complaint. (See Item 11)

ITEM 9 (8a) While it is true that PHS will acknowledge receipt of the complaint and, after investigation, advise the claimant of the outcome, an explanation of types of benefits covered seems to be needed here. Please return to Item 8 and choose another answer.

ITEM 10 (8b) You're partly right. The explanation is correct, but we cannot tell a claimant not to file a complaint. Return to Item 8 and choose another answer.

ITEM 11 (8c) Correct. The fees of surgeons in private practice are not covered under hospital insurance and the claimant should be so advised, but the decision as to whether to file a complaint should be left to the claimant.

ITEM 12 If the claimant decides to file a complaint, the interviewer should assist the claimant in documenting the complaint of discrimination, advise the claimant of the procedure, and explain that further contact should be with PHS.

The complaint may be filed by the individual or through a representative. If the individual is reluctant to reveal their identity, an anonymous complaint will be accepted. The claimant may deal directly with PHS. In any case, the confidentiality of the information must be safeguarded.

The claimant tells the interviewer of discrimination by a local hospital in the type of accommodations received, but is reluctant to file a complaint for fear of being treated worse if the claimant has to return to the hospital. The claimant should be told:

a. That a signed complaint may be filed through the Social Security office or directly with PHS, but the claimant's name will be kept confidential. (See Item 13)

b. That the claimant may file a complaint either through the Social Security offfice or directly with PHS, either with or without the claimant's name. If used, the claimant's name will be kept confidential. (See Item 14)

ITEM 13 (12a) Remember the complaint need not be signed. Return to Item 12 and choose another answer.

ITEM 14 (12b) Right! All points are covered here: The complaint may be filed with the Social Security office or with PHS directly, and may be signed or anonymous. The confidentiality of the complaint must be safeguarded.

ITEM 15 Each provider of services must file an agreement with the Secretary of Health, Education, and Welfare not to charge beneficiaries for covered services and to make adequate provision for refund of erroneous charges. Providers of services can still charge each individual the amount of the deductible, coinsurance, and for any uncovered services.

Hill Top Nursing Home meets all requirements of a skilled nursing facility. Hill Top has also filed its agreement not to charge beneficiaries for covered services and to make adequate provision for refund of erroneous charges. Thus, Hill Top Nursing Home is eligible to participate in the hospital insurance program and to receive benefit payments for covered services provided to beneficiaries. Which of the following statements is true?

a. Hill Top is qualified and eligible to participate in the HI program. (See Item 16)

b. Hill Top Nursing Home is not a provider of services, and benefit payments can only be made to providers of services. (See Item 17)

ITEM 16 (15a) Excellent! Hill Top Nursing Home has met all the requirements for participation in the hospital insurance program and is eligible to receive benefit payments for covered services provided to beneficiaries. Go on to Item 18.

ITEM 17 (15b) You say, "Hill Top Nursing Home is not a provider of services." Why not? Qualified hospitals, skilled nursing facilities, and home health agencies are providers of services under Part A, and Hill Top is a qualified skilled nursing facility. Please return to Item 15 and choose another answer.

ITEM 18 East County Hospital is also fully eligible to receive benefit payments for covered services. Beneficiary Rita Krebs spent 1 week as an inpatient in East County Hospital during January 1980. The hospital's charges for her stay (excluding physicians' charges) are outlined below. January 9 began a new benefit period.

January 9 Rita enters hospital

Private room (at her request) and board*	$135/day
Drugs prescribed by doctor	$100 (total)
Television rental	$2/day

January 16 Rita leaves hospital

*East County Hospital charges $125/day for semi-private room and board.

How much will Rita have to pay East County Hospital as her share of the cost for her 7-day stay?

a. $180 (See Item 19)

b. $90 (See Item 20)

c. $264 (See Item 21)

d. $1059 (See Item 22)

ITEM 19 (18a) Your answer is $180. This amount is the inpatient hospital deductible which a hospital can charge beneficiaries, for benefit periods beginning in 1980, and which is applied to the first 60 days of that benefit period. However, hospitals can also charge beneficiaries for any services that are not covered by the hospital insurance program. Since Rita did receive noncovered services, return to Item 18 and choose another answer.

ITEM 20 (18b) $90 is the cost of services not covered by the hospital insurance program. However, hospitals can also charge beneficiaries the deductible for covered inpatient services. Please return to Item 18 and choose another answer.

ITEM 21 (18c) $264 is correct. Rita would be responsible for the first $180 plus the difference in charges between a semi-private and private room. The cost of the private room would be covered only if it were medically necessary. She would also have to pay the charge for the television rental since this is a personal convenience and consequently not covered. Go on to Item 23.

ITEM 22 (18d) $1059 is the total bill for Rita's hospital stay, but participating hospitals cannot, by virtue of their agreement with the Secretary of Health, Education, and Welfare, charge beneficiaries for covered services. Since part of the $1059 total cost is for covered services, the hospital can only charge Rita a lesser amount. Please return to Item 18 and choose another answer.

ITEM 23 Providers of services receive their benefit payments from fiscal intermediaries (usually called just "intermediaries"). In most instances, a group of providers will nominate an organization to act as intermediary for the members of the group. The intermediary may be any national, State, or other public or private organization or agency.

If the Secretary finds that the nominated organization is qualified, the Secretary enters into an agreement with the organization to make benefit payments to providers who are members of that organization. A member provider acting alone may not nominate just any intermediary. But, a member provider is not required to deal with the intermediary nominated by its association. A provider may request instead to deal with any other fiscal intermediary with which the Secretary has signed an agreement, or it may deal directly with the Health Care Financing Administration. (The latter course does not afford any financial advantages.) Providers not belonging to any group or association are also restricted to dealing with an intermediary already nominated by some association.

Blue Cross has been nominated to act as intermediary for the members of North District Hospital Association. Hillside Hospital is a member of NDHA. Which of the statements below is accurate?

a. Blue Cross will arrange to have the Health Care Financing Administration reimburse the Hillside Hospital for the cost of services under the hospital insurance program. (See Item 24)

b. Blue Cross will be an intermediary if it enters into an agreement with the Secretary and pays for the cost of covered services to the Hillside Hospital. (See Item 25)

ITEM 24 (23a) This is not an accurate statement. The term "intermediary" implies that the transactions between the Secretary and the providers of services will be handled by a third party (in this case, Blue Cross). Please return to Item 23, then read the correct answer below.

ITEM 25 (23b) Your answer is correct. The provider of services (in this case the Hillside Hospital) will be paid directly by the intermediary (Blue Cross) since Blue Cross has been nominated as the intermediary and has entered into an agreement with the Secretary. Now go on to Item 26.

ITEM 26 These agreements with the Secretary provide for the intermediary to determine the amount of benefits which should be paid to providers and to make these benefit payments to the providers. The intermediary is then reimbursed by the Federal Government.

In determining the amount of Medicare benefit payments due a provider, the intermediary bases its reimbursement on a "reasonable cost" concept. In arriving at the reasonable cost of services, most cost items (cost to the provider), such as depreciation, cost of equipment, supplies, and labor, are taken into consideration. Excluded as cost items would be costs of operating gift shops in the hospital, financing building drives, and conducting pure research. Reimbursement to the hospital of providing bed and board is based on the reasonable cost of semi-private accommodations.

Of the following, select the group which contains only those expenses that can be considered cost items in arriving at reasonable costs:

a. Light, heat, cost of food, depreciation, office salaries, and salary of interns. (See Item 27)

b. Nurses' salaries, cost of an X-ray machine, lunches for workers on the building committee, and elevator maintenance. (See Item 28)

ITEM 27 (26a) The answer is correct. All of the cost items mentioned, such as light, heat, cost of supplies, depreciation, office salaries, and salaries of interns are operating expenses that are taken into consideration in computing reasonable cost. Now go on to Item 29.

ITEM 28 (26b) Certain salaries (such as nurses'), the cost of certain equipment (such as the X-ray machine), and the maintenance costs for elevators are operating costs that are considered when arriving at reasonable costs for hospitals. Lunches for workers on a building committee, however, or any other expenses connected with the raising of money for a hospital, are not expenses that can be used in computing reasonable cost. Please return to Item 26 and select another answer.

ITEM 29 As you have already learned, the inpatient hospital deductible is $180 for benefit periods beginning in 1980.

For benefit periods beginning in 1980 and in each succeeding calendar year thereafter, revised Part A deductible rates will be determined by the Secretary during the period July 1 - October 1 of the preceding year, based on changes in the cost of hospital services.

Now let us check your understanding:

a. The inpatient hospital deductible may be increased at any time after January 1, 1980, by the Secretary, if increased hospital costs warrant an increase. The Secretary's decision must be published in the Federal Register. (See Item 30)

b. The inpatient hospital deductible may be revised for benefit periods beginning on or after January 1, 1980, based on changes in the cost of hospital services. This determination will be made between July 1 and October 1 of the previous year. (See Item 31)

ITEM 30 (29a) Did we say that? There is a definite limit on the time a deductible change can be made. At any rate, we said nothing about the Federal Register although that was a good guess. Now return to Item 29 then read the correct response below.

ITEM 31 (29b) This answer is correct. All Part A deductible changes will be effective on January 1 of the particular year, and the decision must be made and published during the third quarter of the preceding year. This gives the public a few months' advance notice on such changes.

ITEM 32 The effective date for inpatient benefits under the hospital insurance program was July 1, 1966, for in-hospital services and home health services. However, for posthospital extended care services, the effective date for coverage was January 1, 1967. In no event were benefits payable before these effective dates. Like RSDI claims there is a 12-month retroactive period for entitlement to hospital insurance benefits. However, unlike RSDI benefits, benefits under the hospital insurance program terminate with the month of death rather than with the month before the month of death; and, unlike RSDI benefits, hospital insurance benefits are payable for part of a month.

Clara Jones was in the hospital during the months of July and August 1977. She died while in the hospital on August 17, 1977. After the deductible has been taken care of:

a. The hospital will be paid for covered services under the HI program for the month of July only. (See Item 33)

b. Clara's estate will also have to pay for the cost of drugs used during her treatment but will not have to pay for any other services through the date of death. (See Item 34)

c. All covered services for the months of July and August, up to and ending with the date of death, will be paid for under the HI program. (See Item 35)

ITEM 33 (32a) The hospital will be paid for covered services provided during July, of course. However, benefit payments under the hospital insurance program do not terminate with the month before the month of death as do RSDI benefits. Under the hospital insurance program services are covered up through the date of the patient's death. Please return to Item 32 and choose another answer.

ITEM 34 (32b) Just a moment now. The hospital insurance program covers all ordinary hospital services, including drugs. Benefit payments are made for all covered services as long as the beneficiary remains entitled to them. Please return to Item 32 and choose another answer.

ITEM 35 (32c) Your answer is correct. All covered services for the months of July and August, up through August 17, the date of death, will be paid for under the hospital insurance program. Unlike other Social Security benefits, benefits under the hospital insurance program terminate with the month of death and not with the month before the month of death. Go to Item 36.

ITEM 36 The physician has a very important part in the administration of the hospital insurance program. The physician must approve the admission of a patient to a hospital, order tests, drugs, and treatments, and determine the length of stay. For this reason, payment of benefits can be made only if a physician certifies to the medical necessity of the services furnished. If services are furnished over a period of time, recertification by the physician is necessary. Written certification of medical necessity is not required for general hospital admissions or for outpatient services in recognition of the fact that admission or the rendering of outpatient services in itself ordinarily attests to medical need.

The Federal Government, of course, has no authority to supervise or control the practice of medicine. This means that the patient will retain complete freedom of choice in the selection of a personal physician, or a provider of services.

Beneficiary Bill Foss has heard from some of his friends that Medicare is really "socialized medicine." He is concerned about his free choice of doctor and "Government running the practice of medicine." What would you tell Mr. Foss in order to clarify his impressions?

a. The Federal Government will not interfere with the ordinary practice of medicine by physicians outside of hospitals, but will set up standards and regulations for their practice in participating hospitals. (See Item 37)

b. Individuals will still be able to select their own doctor. Government physicians will only be used to certify to the necessity of covered services. (See Item 38)

c. A beneficiary's personal physician will not in any way be under Goverment supervision or control. He must cooperate with certain certification procedures, however, if benefits are to be paid for covered services. (See Item 39)

ITEM 37 (36a) This is not true. The Federal Government will not interfere with the practice of medicine by physicians outside the hospitals or inside the hospitals. Nor will the Government interefere with the administration of hospitals or other medical facilities. Please return to Item 36 and choose another answer.

ITEM 38 (36b) You may be somewhat confused here. Individuals will be able to select their own doctor. The Government will not interfere with the practice of medicine. Although a physician will have to recertify to the medical necessity of covered services where services are furnished over an extended period of time, the doctor involved will usually be the patient's private physician. These physicians will not be working for the Federal Government. Please return to Item 36 and choose another answer.

ITEM 39 (36c) You are right again. The Federal Government will not have any control over the practice of medicine or the selection of a personal physician. However, in order for benefit payments to be made under Part A, the beneficiary's physician must recertify periodically that the covered services are medically necessary where services are furnished over a long period of time. (Remember, we assume medical necessity at the time of initial admission to a general hospital.) In the case of inpatient hospital services for which payment can be made, the physician would have to recertify that the services are required for the individual's medical treatment as of the 12th day after admission, as of the 18th day, and again no later than every 30 days. Certification on admission is required in certain instances.

ITEM 40 In the case of posthospital extended care services, a physician must certify that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which inpatient hospital services has been received, and which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. And for posthospital home health services, the physician must certify that the individual is confined at home, and needs either skilled nursing care on an intermittent basis, physical therapy or speech therapy, for treatment of a condition for which the individual has received inpatient hospital services or posthospital extended care.

In the case of inpatient psychiatric hospital services, a physician must certify that the psychiatric services can reasonably be expected to improve the patient's condition or are for medically necessary diagnostic study. The intent here is to assure that only active treatment, and not custodial-type care, is being paid for under the hospital insurance program.

Finally, for the same reason, tuberculosis hospital services can be covered only where the physician certifies that the treatment can reasonably be expected to improve the condition for which the treatment was necessary, or to render the condition noncommunicable.

Which of the following statements is true?

a. Benefit payments cannot be made for extended care services unless the attending physician certifies that the patient needs, on a daily basis, skilled nursing care or other skilled rehabilitation services for a condition for which inpatient hospital services has been received, or for the treatment of a condition which arose after the individual was transferred to the SNF but while still being treated for a condition for

which inpatient hospital services has been received, which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. (See Item 41)

b. Benefit payments for only certain services can be made without a physician's certification, or assumed certification, as to their medical necessity. (See Item 42)

c. Tuberculosis hospital services cannot be covered unless the treatment is expected to completely cure the patient. (See Item 43)

ITEM 41 (40a) Excellent. A physician's certification as to the medical necessity of extended care services is always required before benefit payments can be made. Extended care services can be covered only if they are for the continued treatment of a condition for which the individual had received inpatient hospital services, or for the treatment of a condition which arose after the individual was transferred to the skilled nursing facility but while still being treated for a condition for which inpatient hospital services had been received.

In addition to the above, the patient must sign a request for payment to be made to the hospital. This is done at the time of admission. If it were impractical for the patient to sign the request when admitted (e.g., the patient is unconscious, incompetent, or in great pain) another person can sign for the patient. This can be a representative payee, friend, relative, or welfare worker. The request is then filed with the intermediary. If there are multiple admissions during one benefit period, a request is required for each inpatient hospital admission. Go on to Item 44.

ITEM 42 (40b) You didn't really mean that, did you? Benefit payments cannot be made for any services without a physician's certification as to their medical necessity. Medical necessity is assumed when a physician admits a patient to a general hospital or when outpatient services are rendered. Please return to Item 40 and choose another answer.

ITEM 43 (40c) Although tuberculosis hospital services can be covered if the physician certifies that the patient can reasonably be expected to be cured, they can also be covered if the physician feels (1) the condition will be improved, or (2) rendered noncommunicable. It should be noted, however, that the intermediary reviewing the case makes the determination that the care provided was of a type and level covered under the program. Now return to Item 40 and choose another answer.

ITEM 44 If the beneficiary is dissatisfied with any determination of Medicare coverage furnished by a provider, the beneficiary is entitled to a reconsideration by the intermediary. Patients protesting that the health insurance program should assume liability for services furnished will be referred by the hospital to the district office. If, after a reconsideration, the individual is still dissatisfied, and the amount in question is $100 or more, the individual may request a hearing. If still dissatisfied, the individual may request a review by the Appeals Council of the Bureau of Hearings and Appeals and, finally, if the amount in controversy is $1,000 or more may request a court review.

When Frank Henry received his bill from City Hospital, it showed that he owed $125 for his private room. He believes this is wrong because his doctor suggested the private room, and he complains to the hospital. The correct action for the hospital is:

a. Have him contact the intermediary who will make the decision. (See Item 45)

b. Refer him to the district office for assistance in filing a request for reconsideration, which will be the final level of appeal in this case. (See Item 46)

c. Refer him to the district office. He can have a reconsideration and if still not satisfied, a hearing. (See Item 47)

ITEM 45 (44a) No. Remember we said that he can receive a reconsideration by the intermediary and that the hospital should refer a beneficiary to the district office. Return to Item 44 and select another answer.

ITEM 46 (44b) Close, but this won't necessarily be the final level of appeal. Since the amount in question is over $100 a hearing can be granted if the individual is still dissatisfied after receiving the reconsidered determination. Return to Item 44 and select another answer.

ITEM 47 (44c) Right. He is entitled to a reconsideration and since over $100 is in question, he would also have the right to a hearing. Now go on to the next page. You will be using the mask for a while.

Let us review what we have learned in this section. Payments for covered services are made to the _____ of services. (i.e., hospitals, skilled nursing facilities or home health agencies.)	provider
To receive payment a provider of services must agree not to charge beneficiaries for covered services and to make provision for refund of erroneous charges. True or False? _____.	True
Benefits will be paid to participating providers of services by fiscal _____.	intermediaries
An intermediary can be any national, State or other public agency selected by a group or association of providers of _____.	services
The Secretary enters into agreements with selected intermediaries to pay providers of services for the services covered under Part A on a "_____" basis.	reasonable cost

Among other things, the intermediary will: (Select one) a. Make determinations as to eligibility for benefits. b. Serve as a channel of communication between the providers of services and the Secretary, and vice-versa.	b
The fiscal intermediary will not however: (Select one) a. Make audits of the provider records to insure proper payment. b. Assist providers in providing safeguards against unnecessary utilization of services. c. Determine what treatment the doctor should prescribe for a beneficiary.	c
In arriving at "reasonable costs", the cost to a hospital of providing bed and board will be the cost of _____ - _____ accommodations.	semi-private
In arriving at reasonable costs for hospitals, which of the following cannot be included: a. depreciation of buildings b. cost of repair to existing facilities c. light and heat d. salaries of nurses and aides e. the cost of gift shop operation f. the cost of a new X-ray machine	e. the cost of gift shop operation
We have also learned that the inpatient hospital deductible is $180 for benefit periods beginning _____.	January 1, 1980

For benefit periods beginning in 1980 and each succeeding calendar year, the deductible amount will be determined by the Secretary between July 1 and October 1 of the previous year. True of False?	True
In addition, we learned that like all other types of OASDI benefits, there is a _____-month retroactive period (how many) for entitlement to premium-free hospital insurance benefits.	12
However, benefits will not be paid for the month of death. True or False?	False (Benefits under the HI program may be paid for the month of death.)
Another point covered was that payment of benefits can only be made if the medical necessity of the services is certified by the beneficiary's _____. (Medical necessity is assumed in certain cases.)	physician
We also learned that the patient _____ (can/cannot) select his own doctor . . . READ ON	can

and that the Government has no authority to supervise or control the practice of _____.	medicine
In the case of admission for inpatient hospital services in a general hospital, a physician's written certification that the services are necessary for the individual's medical treatment is not required because the medical necessity can be assumed from the fact of admission. True of False: _____.	True
In cases of post-hospital extended care, a physician must certify that the care is required because of the need, on a daily basis, for skilled nursing services, or skilled rehabilitation services which as a practical matter can be provided only in a SNF on an inpatient basis for any condition. True of False: _____.	False. (Care must be for the same condition for which inpatient hospital care has been received or for a condition which arose while the patient was in the SNF receiving treatment for that condition.)
And in the cases of post-hospital home health services, he physician must certify that the beneficiary is confined to home and needs either skilled nursing care on an intermittent basis, physical therapy or speech therapy for treatment of a condition for which inpatient hospital services or covered posthospital _____ _____ has been received.	extended care
With respect to psychiatric hospitals, the physician must certify in writing that the treatment could reasonably be expected to improve the condition or was for a medically necessary diagnosis. This distinguishes active treatment (covered) from purely _____ care (not covered).	custodial

Before any payment can be made, the patient or the patient's _____ must sign a request for payment.	representative
Requests for reconsiderations involving whether payment of expenses are covered by the hospital insurance program _____ be accepted by the Social Security office, which in turn forwards the request to the servicing intermediary. (may/may not)	may
The amount in question must be $_____ or more before a hearing can be granted, while the amount must be $_____ or more before a court review may be requested.	$100 $1,000
Congratulations! You have completed the longest of the three programmed learning texts on Medicare. You should have a good general, yet comprehensive, knowledge of the hospital insurance benefits program. The benefits provided under Part B of Medicare are described in Medical Insurance Benefits -- A Programmed Learning Text.	

JULIAN DATE CALENDAR

(PERPETUAL)

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

FOR LEAP YEAR USE REVERSE SIDE

JULIAN DATE CALENDAR

For Leap Years Only

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
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5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
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13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
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25	025	056	085	116	146	177	207	238	269	299	330	360	25
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27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

(USE IN 1964, 1968, 1972, etc.)

COMMENTS ON

HOSPITAL INSURANCE BENEFITS

As a user of this booklet, your opinion on the following is solicited:

1. In what way did you find the book useful?

2. How would you improve the booklet?

3. What Medicare-related topics would you suggest for similar publications?

4. What is your organization and position?

Address comments to:

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389 East High Rise
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